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ABSTRACT

The World Summit for children was held at the United Nations, New York, on September 30, 1990. The summit set child health goals to be achieved by the year 2000, and offered strategies and guiding principles for achieving the goals. The summit proposed a new ethic for children which called for children's needs to be given high priority in the allocation of resources. The summit considered topics relevant to the problem of world population, and summit panels set goals for various problem areas, including: (1) deaths of children under five years; (2) maternal mortality; (3) malnutrition; (4) pneumonia and diarrhea; (5) lack of immunization; (6) poor control of the number and timing of births; (7) decrease in breastfeeding; (8) lack of basic education; (9) poor water quality and sanitation; (10) inadequate health education; (11) AIDS; (12) Guinea worm disease; (13) vitamin A and iodine deficiencies; (14) and insufficient protection of children at work and during war. The Summit's World Declaration on the Survival, Protection and Development of Children; the plan of action for implementing the World Declaration; and the 54 articles of the Convention on the Rights of the Child are included. Tables present worldwide statistics concerning such topics as nutrition, health, education, demography, economics, and women. (BC)

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THE STATE OF THE WORLD'S CHILDREN
1991

James P. Grant
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United Nations Children's Fund
(UNICEF)

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THE STATE OF THE WORLD'S CHILDREN 1991

James P. Grant

The promise to children

Keeping the promise

The principles of success

A new ethic for children

The population question

Conclusion

The under-five mortality rate (U5MR) is the number of children who die before the age of five for every 1,000 live births. It is the principal indicator used by UNICEF to measure levels of, and changes in, the well-being of children. The U5MR also governs the order in which countries are listed in the statistical tables annexed to the State of the World's Children report.

Figures given for the U5MR of particular countries, in both the text and statistical tables, are derived from data prepared by the United Nations Population Division on an internationally comparable basis using various sources. In some cases these estimates may differ from the latest national figures.

The promise to children

On Sunday, September 30th, 1990, a great promise was made to the children of the 1990s. On that day, 71 Presidents and Prime Ministers came together for the first World Summit for Children. It was the largest gathering of heads of state and government in history. And the outcome was an extraordinary new commitment - a decision to try to end child deaths and child malnutrition on today's scale by the year 2000 - and to provide basic protection for the normal physical and mental development of all the world's children.

This overall goal was broken down into more than 20 specific targets listed in the Plan of Action agreed on by the 159 nations represented at the Summit. All governments will review their plans and budgets and decide on national programmes of action before the end of 1991.

"*We are prepared to make available the resources to meet these commitments*", said the final Declaration. All national and international organizations have been asked to participate. In particular, the worlds of religion, education, the communications media, business, and the non-governmental organizations in every country are invited to join this decade-long effort.

As the Summit met, the world was nearing the deadline set just over 10 years ago for reaching another great human goal - 80% immunization coverage for the children of the developing world. At the time, approximately 15% were being immunized. Today, despite all the difficulties of the last decade, the 80% goal is expected to have been reached when the latest figures become available early in 1991 (fig. 1 panel 6)*.

That extraordinary effort has saved over 12 million young lives and prevented over one and a half million children from being crippled by polio (figs. 2 and 5).

It has also given the world new hope by showing what can be achieved when the international community commits itself to a great endeavour.

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* The goal of immunizing 80% of children under the age of one is expected to have been reached for the developing world as a whole on the basis of the percentage of infants who have received the necessary three shots of DPT vaccine (considered by WHO and UNICEF to be a good indicator of the effectiveness of the immunization system as a whole). For BCG, the target has already been surpassed. For Polio (three shots) overall coverage of 78% by 1989 is expected to rise beyond the 80% target by the end of 1990. Measles immunization, which is not normally given before the age of nine months and which began the decade at very low levels, reached 71% in 1989 and may still lag a few percentage points behind as 1990 ends.

The diseases which vaccines prevent are also major causes of child malnutrition; the immunization effort of the last decade has therefore also kept uncounted millions of children from the downward spiral of frequent illness, poor growth and early death.

The year 2000: what can be achieved?

The following is the full list of goals, to be attained by the year 2000, which were adopted by the World Summit for Children on September 30th 1990. After widespread consultation among governments and the agencies of the United Nations, these targets were considered to be feasible and financially affordable over the course of the decade ahead.

Overall goals 1990-2000

- A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births - whichever is less).
- A halving of maternal mortality rates.
- A halving of severe and moderate malnutrition among the world's under-fives.
- Safe water and sanitation for all families.
- Basic education for all children and completion of primary education by at least 80%.
- A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.
- Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted *Convention on the Rights of the Child*. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

Protection for girls and women

- Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'.
- All women to have access to pre-natal care, a trained attendant during childbirth and referral for high-risk pregnancies and obstetric emergencies.
- Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy and lactation.

Nutrition

- A reduction in the incidence of low birth weight (2.5 kg. or less) to less than 10%.
- A one-third reduction in iron deficiency anaemia among women.
- Virtual elimination of vitamin A deficiency and iodine deficiency disorders.
- All families to know the importance of supporting women in the task of exclusive breast-feeding for the first four to six months of a child's life and of meeting the special feeding needs of a young child through the vulnerable years.
- Growth monitoring and promotion to be institutionalised in all countries.
- Dissemination of knowledge to enable all families to ensure household food security.

Child health

- The eradication of polio.
- The elimination of neonatal tetanus (by 1995).
- A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.
- Achievement and maintenance of at least 85% immunization coverage of one-year-old children and universal tetanus immunization for women in the child-bearing years.
- A halving of child deaths caused by diarrhoea and a 25% reduction in the incidence of diarrhoeal diseases.
- A one-third reduction in child deaths caused by acute respiratory infections.
- The elimination of guinea worm disease.

Education

- In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.

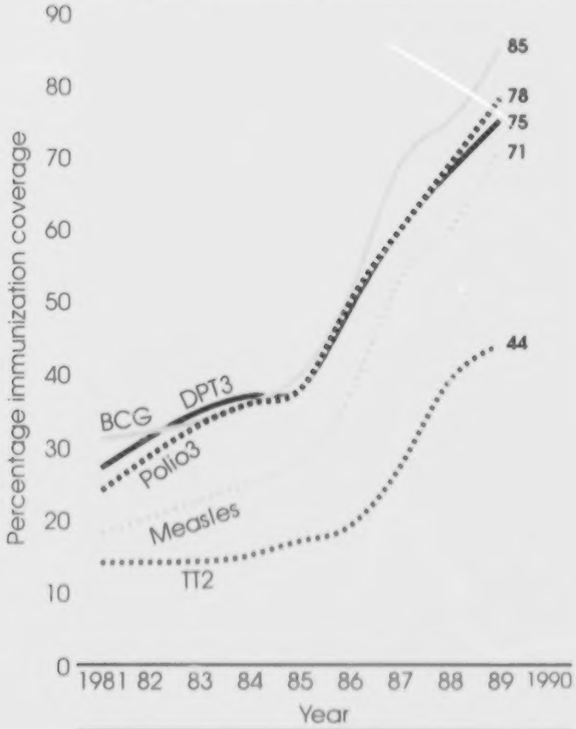
The quiet catastrophe

Two principal facts dominated the World Summit for Children.

The first was the fact of the quiet catastrophe - the 40,000 child deaths each day from ordinary malnutrition and disease, the 150 million children who live on with ill health and poor growth, the 100 million 6 to 11-year-olds who are not in school.

Fig.1 Increase in immunization coverage for infants in developing countries, 1981-89

The graph shows the developing world's progress towards the target of 80% immunization by the end of 1990. Figures for 1990 will be available in early 1991. China is not included in the data until 1986.



TT2 = two anti-tetanus injections, during pregnancy, to protect against tetanus of the new-born.

Source: WHO and UNICEF

The second was the fact that the means of ending this quiet catastrophe are now both available and affordable. Large-scale trials and studies in many nations in recent years have vastly increased both the world's understanding of the problems and its capacity to solve them.

The question at the centre of the World Summit was therefore whether morality would keep step with capacity, whether what *could* now be done *would* now be done.

It was a question given an extra dimension by the fact that the Summit for Children came less than two months after the United Nations had been called upon to act in response to the crisis in the Persian Gulf. The juxtaposition of these two major events at the United Nations could not have been more poignant; for it posed the question of whether the international community was prepared to act on the important as well as on the immediate, and in the interests of the powerless as well as those of the powerful.

None of these questions could be answered in full at the Summit itself. For they are questions which will be answered not by the declarations of a day but by the deeds of a decade.

But what did emerge from that Sunday in September was an entirely new commitment to the children of the quiet catastrophe.

On that Sunday, for the first time, the centre of the stage was occupied not by the victims of any sudden disaster, any earthquake, famine, or flood, but by the children who are the victims of the much greater daily disaster of malnutrition and disease. For the first time, their case was put before the assembled political leaders of the world. For the first time, their voice went out around the world. For the first time, their claim was acknowledged by headlines in virtually every country. And if the world keeps faith with the commitments made that day, then of these children it might at last be said that their time has come.

Under-five deaths: a one-third reduction

Year 2000 goal: A one-third reduction in 1990 under-five mortality rates (or a reduction to below 70 per 1,000 live births - whichever is less).

On present trends, approximately 130 million children will die of disease and malnutrition in the decade of the 1990s.

The combined effect of achieving the year 2000 goals discussed in these panels, would be to reduce the overall child death rate by at least one third. Paradoxically, it would also help to slow population growth as parents become more confident that their existing children will survive (panel 7).

The individual year 2000 goals most directly related to reducing child deaths include:

○ *Elimination of neo-natal tetanus.* Tetanus, which can be prevented by good hygiene during and after the birth and by immunization of women before or during pregnancy, is today responsible for approximately 800,000 infant deaths each year (panel 6).

○ *A 95% reduction in measles deaths.* Measles, usually preventable by immunization, kills approximately 1.5 million young children each year (panel 6) and is a major cause of malnutrition.

○ *A halving of child deaths caused by diarrhoea.* Diarrhoeal disease, which can usually be avoided by improved hygiene, kills 4 million children each year. Sixty per cent of those deaths are a result of dehydration, and could be prevented by low-cost oral rehydration therapy (panel 5).

○ *A one-third reduction in child deaths caused by acute respiratory infections.* Low-cost antibiotics can prevent most of the more than 2 million child deaths a year now caused by acute respiratory infections (not including those precipitated by vaccine-preventable disease).

○ *Family planning education and services to be made available to all couples.* The risks to the life of both mother and child are at least doubled when births occur closer together than 2 years (panel 8).

○ *Promotion of breast-feeding.* In poor communities, death in childhood is at least twice as common among those who are not exclusively breast-fed for the first four to six months of life (panel 9).

○ *The virtual elimination of vitamin A deficiency.* Differences in mortality rates of up to 30% have been found between groups of children with and without vitamin A deficiency (panel 15).

○ *Reducing the incidence of low birth weight to less than 10%.* Babies weighing less than 2.5 kg. or more at birth are approximately twice as likely to die (panel 4).

○ *A 50% reduction in child malnutrition.* Poor nutritional health is a major factor in perhaps one third of all child deaths (panel 4).

○ *Universal basic education, a halving of adult illiteracy and equal educational opportunities for girls and women.* Of all the factors associated with improved child survival, female education has been shown to be the most important (panel 10).

○ *Universal access to clean water and safe sanitation.* Improved hygiene can prevent illnesses such as diarrhoea, and the malnutrition which frequent illness causes. Safe, convenient water supplies would also reduce the work-loads of women and girls and allow time for improvements in child care (panel 11).

If progress can be made towards all of these major goals, then the net effect on child survival would be much greater than the sum of the parts. Many of the threats to child health act synergistically, pushing the child into a self-reinforcing downward spiral of infection and malnutrition. It is this syndrome, more than any specific incident, which underlies the deaths of so many millions of children each year and the malnutrition of so many millions more. And it is this syndrome which could be broken by the *combination* of specific low-cost actions which make up the year 2000 goals.

A record of intention

The 22 specific targets to be achieved by the year 2000 are discussed in the panels inset into this year's report and listed in full in panel 1 on page 2. The Declaration and Plan of Action adopted by the Summit are also published in full (pages 49 to 73). With the full text of the Convention on the Rights of the Child (pages 75 to 96), this year's *State of the World's Children* report serves as a basic record of the commitment made by the world community, in respect of its children, for the decade ahead.

The seven overarching goals adopted for the year 2000 by the Summit may be summarized as follows:

○ *Reduction of 1990 under-five child mortality rates by one third or to a level of 70 per 1,000 live births, whichever is the greater reduction.*

At present, approximately 14 million children under five are dying each year in the developing world* - more than a quarter of a million each week. The immediate causes of more than 60% of those deaths can be numbered on the fingers of one hand - diarrhoeal disease, measles, tetanus, whooping cough and pneumonia. All of these can now be prevented or treated at very low cost (panel 2). Several countries with per capita GNPs of under $1,500 a year - including

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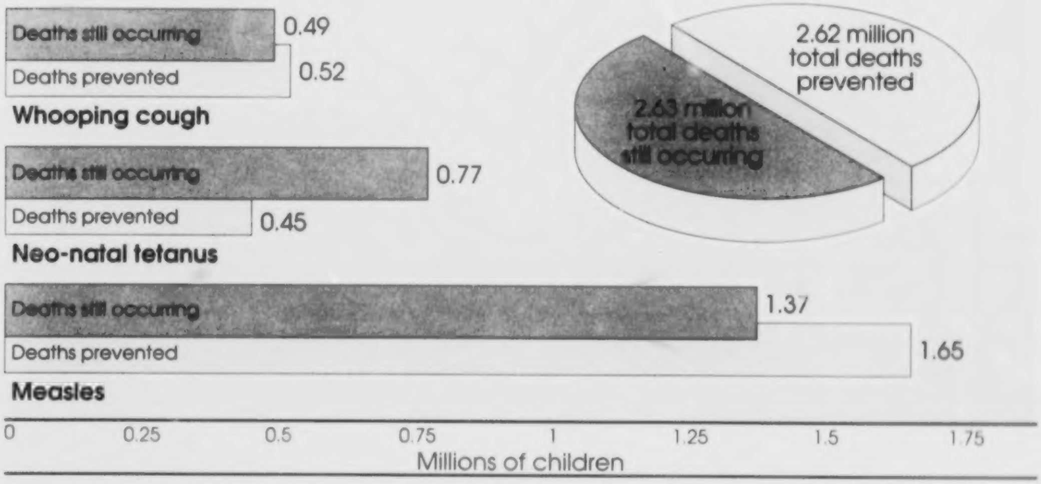
* Without the progress of the 1980s, under-five deaths would have risen to an annual total of approximately 17.5 million by 1990 because of population increase and an upward revision of population estimates. The advance of basic child survival strategies such as oral rehydration therapy (ORT) and immunization in the 1980s is now saving approximately 3.5 million lives each year. The annual total of under-five deaths therefore remains at approximately 14 million.

Fig.2 Child deaths prevented by vaccines, developing world, 1990

The annual number of child deaths from all vaccine preventable disease in the developing world has now been halved – saving approximately two and a half million young lives each year. This has been achieved by immunization programmes which now reach approximately 80% of all children.

The task for the 1990s is to sustain this achievement and to extend it to the remaining 20% – generally the poorer and harder to reach – among whom disease has always been more common and more commonly fatal.



Source: World Health Organization, Expanded Programme on Immunization, Information system report, July 1990, Tables 2 and 3, WHO, Geneva.

Chile, China, Jamaica, Mauritius, Sri Lanka and Thailand - have already succeeded in reducing under-five death rates to less than 50 per 1,000.

○ *Reduction of maternal mortality rates to half of 1990 levels.*

At present, approximately 500,000 women are dying every year - one young woman each minute - because something has gone wrong in pregnancy or childbirth. Many of those deaths follow long hours of agony and fear. And many of those women leave behind motherless children. At least half of all maternal deaths could now be prevented by elementary, low-cost means (panel 3).

○ *Reduction of severe and moderate malnutrition among under-five children by one half of 1990 levels.*

At present, one child in every three in the developing world is prevented from growing to his or her mental and physical potential by persistent malnutrition. Many parents are unable to feed their children adequately because of war or famine or because they do not have the land to grow food or the jobs and the income to buy it. But the majority of child malnutrition occurs in households where there is sufficient food. The cause is the frequency of illness and a lack of knowledge about the special feeding needs of the young child. Today's knowledge about birth spacing, breast-feeding, weaning, growth promotion, and the prevention and treatment of common illnesses, plus well-targeted food supplements, has shown that the problem of mass child malnutrition can be overcome at an average annual cost of approximately $10 per child (panel 4).

○ *Universal access to safe drinking water and to sanitary means of excreta disposal.*

At present, more than one third of all families in the rural areas of the developing world do not have access to clean water and one half do not have safe sanitation (fig. 3). Yet costs have fallen dramatically in the last decade. The average initial investment required to provide both safe water and sanitation is now less than $30 per person, and the recurring cost can be as low as $1 or $2 per person per year (panel 11).

○ *Universal access to basic education and completion of primary education by at least 80% of primary school age children.*

At present, only 55% of children in the developing world complete four years of primary education. Boys have twice as much chance of becoming literate as girls, despite the fact that the education of girls is probably the best single investment that any country can make in its future health and well-being. In recent years, low-cost strategies have succeeded in providing the vast majority of children with at least five years of basic education even in some of the world's poorest countries (panel 10).

○ *Reduction of the adult illiteracy rate to at least half its 1990 level, with emphasis on female literacy.*

At present, there are over 900 million adults in the world who cannot read or write. Two thirds of them are women.

○ *Protection of children in especially difficult circumstances, particularly in situations of armed conflicts.*

At present, an estimated 80 million children are exploited in the workplace and 30 million are left to fend for themselves on city streets. Millions more are victims of war, their development disrupted by the interruption of food supplies, the closing of schools and clinics, and the destruction of homes, roads and crops (panel 16).

A practical investment

This range of goals for the year 2000 will clearly be more difficult to accomplish, by several orders of magnitude, than any targets previously attempted. It will demand an extraordinary effort, stepped up over the next two years and sustained throughout the decade, by individual nations, by the United Nations family, by the international community, and by non-governmental organizations and members of the public in every country.

But if the demands are great, then so are the incentives. Basic protection for the lives and the normal growth of all the world's children is not only the greatest of all humanitarian causes; it is also the greatest of all practical investments.

It is a practical investment because vast numbers of unnecessary child deaths increase population growth by pushing millions of parents into having more children than they want in order that some may survive (panel 7 and chapter V).

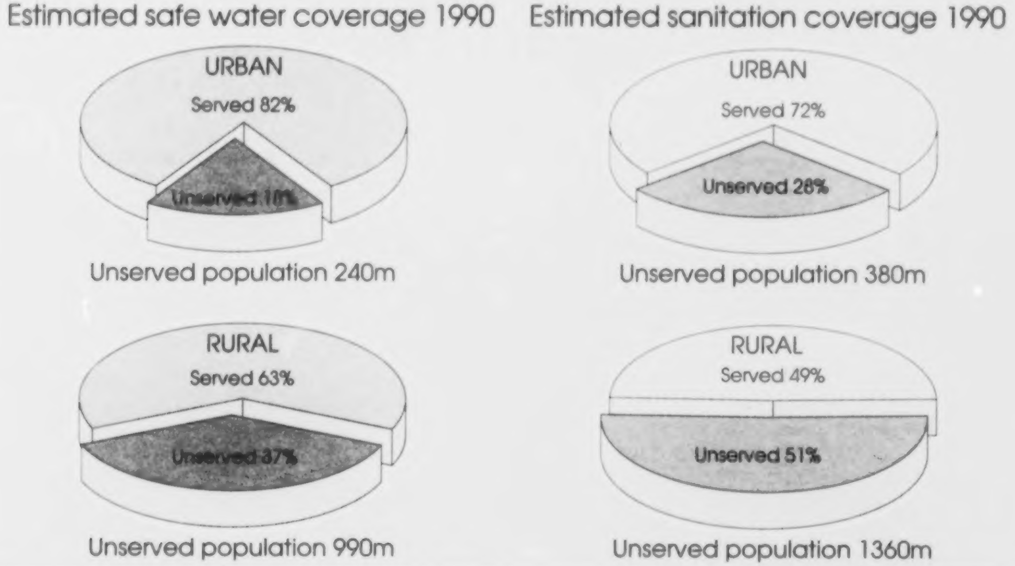
It is a practical investment because persistent malnutrition saps the physical and mental development of people and, ultimately, the economic and social development of nations.

It is a practical investment because even four years of basic education can make a significant difference to productivity and incomes as well as to child health and the acceptance of family planning.

It is a practical investment because basic education for every child is also a fundamental prerequisite for environmentally sound development in the years to come. The choices which today's children will have to make in the twenty-first century, whether they be choices about family size or land use, energy source or waste disposal, can only be made wisely by a population which is capable of absorbing new knowledge and responding to it. Environmentally sustainable human development will therefore depend in large measure on the level of commitment which is made to education in the decade ahead (panel 17).

Fig.3 Safe water and sanitation

The year 2000 target of universal access to safe water and sanitation will be one of the most difficult to achieve. The rate of expansion of water supply achieved during the 1980s, for example, will have to be increased by a factor of two and a half during the 1990s if the goal is to be reached.



Source: UNICEF estimates based on WHO data

Maternal mortality: a 50% reduction

Year 2000 goal: a halving of the 1990 maternal mortality rates.

Every year, an estimated half a million women die of causes related to pregnancy and childbirth. Many die after prolonged agony and fear. And their deaths leave 1 million children motherless.

The causes are haemorrhage, infection, toxaemia, anaemia, obstructed labour and septic abortion. But the roots of the problem are deeper. As long as the nutrition and education of girls is placed second to that of boys, as long as women eat last and least and work hardest and longest, as long as the demand for family planning is met only by the abortionist, and as long as the majority of babies are delivered without trained assistance and referral services, then child-bearing will continue to kill a young woman every minute.

Although obviously a factor, poverty is not the most important determinant of maternal mortality rates:

Country	GNP per capita	Maternal mortality rate
Sri Lanka	400	60
China	290	44
Tunisia	1180	310
Paraguay	990	380
Zimbabwe	580	480
Pakistan	350	500

As further evidence, there are many countries which have succeeded in halving child death rates with little or no change in maternal mortality.

A new awareness of the problem is therefore a precondition for achieving the goal. The following are the major low-cost opportunities:

○ One quarter to one third of all maternal deaths occur when births are too close (less than two years) or too many (more than four) or to mothers who are too young (under 18) or too old (over 35). All parents should have this information - and family planning education and services.

○ Between 20% and 30% of all maternal deaths are the result of illegal abortion. Deaths could therefore be cut by meeting the demand for family planning.

○ The risks can be cut by pre-natal care. Even two check-ups during pregnancy can provide low-cost safeguards against anaemia and high blood pressure (both major causes of maternal death). Two injections in pregnancy can also protect both mother and child against tetanus.

○ All births should be attended by a trained person who can ensure the 'three cleans' (clean hands, clean delivery surface, clean cutting and dressing of the cord) and recognize the signs which mean that more qualified help is needed. At present, only 50% of births in the developing world are attended by a trained person.

○ Until maternity units are available for all births, the risk approach can be used to identify women who need 'waiting homes' close to maternity units or who may need urgent transport. All families should therefore be able to recognize the basic signs of increased risk.

○ Families and society as a whole can also help to reduce the risks by ensuring that pregnant and breast-feeding women have more food and more rest than at other times.

The question is inseparable from the wider issue of the status of women, their health and nutrition, their education and their work-load. In particular, adequate nutrition and health care for girls, especially in early childhood and in adolescence, are essential to break the cycle of poor growth which leaves many millions of women physically unprepared for pregnancy and often results in low birthweight and a repetition of the same cycle.

Action on all of these fronts would not only achieve the target of a one-third reduction in maternal mortality rates by the year 2000, it would also immeasurably benefit the lives of many hundreds of millions of women who do survive childbirth but who suffer serious health problems and disabilities as a result, and who are overburdened with too frequent childbearing.

Finally, it is a practical investment because communications technology has ensured that the children born into the 1990s will know more about the world and expect more from it than any previous generation. And if there is one lesson which history insists on, it is that political and social turmoil will follow when persistent poverty and personal tragedy sit side by side with the evident capacity for improvement in the lives of the poor.

The achievement of the goals decided on at the World Summit for Children, however difficult and daunting the prospect, would therefore represent not only one of the greatest humanitarian achievements of this or any other century, but also one of the greatest practical investments which the human race could now make in its future economic prosperity, political stability, and environmental integrity.

The best chance we have

The specific goals which make up this investment have been decided on after a long process of consultation, and endorsed by 159 governments at the largest gathering of political leaders ever assembled. They therefore represent the best chance the world has, in the decade ahead, for a unifying framework of action and a worldwide mobilization by governments, international agencies, educators, religious leaders, health professionals, voluntary organizations, the mass media, the business community, and members of the public.

The goals are undoubtedly ambitious. But while recognizing the difficulties, it is also important to recognize that these are the goals which are the most achievable, the goals for which the knowledge and the technology already exist, the goals which can be achieved at minimum financial and political cost, the goals which, if they are not achieved, will make a mockery of our hopes of meeting the broader challenges of environmentally sustainable human development in the twenty-first century.

Similarly, the resources involved will undoubtedly be difficult to find. But it is also important to recognize that the total cost would be about the same as is now spent on the military *every ten days*. And no cause could lay greater claim to a share of the resources which might now become available if the world were indeed to extricate itself from its long and painful affair with war and embrace instead the challenge of environmentally sustainable development.

That long and difficult journey must begin by taking the most basic, the most obvious, and the most affordable first steps. And it is those steps which have been set out in the Declaration and Plan of Action adopted at the World Summit for Children and published alongside this year's report.

The following chapters look briefly at the economic context of this effort and at some of the lessons which have been learnt in the struggle to reach the immunization goal over the last 10 years. Apart from attempting to identify some of the principles and strategies of success, the report also discusses the need for an underlying new ethic for children in the 1990s. Finally, this year's report addresses the question of whether success in these endeavours would serve only to add to population and environmental pressures or whether, as UNICEF believes, the achievement of the year 2000 goals would help to bring about a stabilization of population growth at an earlier date and at a lower level than would otherwise have been the case.

Malnutrition: a 50% reduction

Year 2000 goal: A halving of severe and moderate malnutrition among the world's under-fives.

The malnutrition of one third of the developing world's children saps the development of people and of nations. But in recent years it has been shown that most child malnutrition can now be prevented at low cost. In the words of the World Bank, *"a direct attack on malnutrition is needed ... and governments willing to make that effort now have effective and affordable measures to make it happen"*.

By the year 2000, it is therefore feasible to aim at a halving of severe and moderate malnutrition among the world's under-fives.

For many parents, the task of feeding children properly is made impossible by absolute poverty. But most child malnutrition occurs in homes where adequate food is available. The cause is frequent disease and the lack of knowledge about the special feeding needs of a young child.

Diarrhoea, measles and respiratory infections take away a child's appetite, inhibit absorption, burn calories and drain nutrients in diarrhoea and sickness. When such illnesses are frequent, malnutrition is the result. Progress towards the other year 2000 goals, and especially immunization, the prevention and treatment of diarrhoea, and safe water and sanitation, would therefore drastically reduce malnutrition.

In addition, six major causes of malnutrition could now be attacked by empowering parents with today's knowledge about child growth. Every parent should know:

○ Breast milk *alone* is the best possible food for the first four to six months. It provides complete nutrition and 'immunizes' the child against common infections.

○ By the age of four to six months, the child needs other foods. Introducing solid foods earlier increases the risk of infection: leaving it until later leads to malnutrition.

○ A child under three years of age needs feeding twice as often as an adult, with smaller amounts of more energy-rich food.

○ Food and drink should not be withheld when a child is ill or has diarrhoea.

○ After an illness, a child needs an extra meal a day for a week to catch up on the growth lost.

○ Leaving at least two years between births is essential for the nutritional health of both mother and child.

Preventing low birth-weight, by improving the nutritional health of women and girls, and by more food and rest in pregnancy, also reduces the risk of malnutrition. One third of babies in the developing world are born weighing less than 2,500 grammes; the year 2000 target is to reduce this to 10% or less.

Monthly weight gain is the most important single indicator of a child's normal growth and is used as such in almost every industrialized country. Several developing countries have also now begun using community health workers to assist mothers with the regular weighing of all children under three. It makes any faltering in growth visible both to parents and health services. And it also helps to target subsidies to the minority of families in which the absolute lack of food is the main problem.

It is also essential to monitor children's growth *nationally*. At the moment, few nations have regular statistics on what percentage of children are growing normally. But there could be no more important guide to policy or more important measure of a nation's real progress.

The potential of these approaches has been widely demonstrated in the 1980s. In several regions of the developing world, child malnutrition has been reduced by 50% at a cost of $10 per child per year.

Keeping the promise

Among the tens of thousands of words which appeared in the world's press following the Summit for Children, one persistent strain was summed up by an editorial in *The New York Times*:

"The largest global Summit meeting in history pledged to do better by the world's children. Their promises were eloquent, their goals ambitious. But children cannot survive or thrive on promises. The world's leaders now have an obligation to find the resources and the political will necessary to translate hope into reality."

In short, can the promise be kept?

That question, and particularly the question of whether the resources can be found, is bound up with the broader picture of economic development in the 1990s. This chapter discusses how the year 2000 goals fit into that broader picture - and addresses the question of where the money might come from.

The economic context

Economic progress in the decade ahead is not the only factor which will influence the progress of nations towards the year 2000 goals. It may not even be the most important factor. Several developing countries have already achieved the goals for under-five mortality and school enrolment despite per capita incomes which are significantly lower than the average for the developing world.

Nonetheless, for most countries, economic progress would make it considerably easier to devote the necessary resources to the task.

The bad news is that the developing world's debt still stands at approximately $1,300 billion, that annual interest repayments on that debt amount to almost $200 billion, that interest and amortization payments exceed new net flows from the industrialized countries by $30 billion, that aid levels are increasing only marginally, and that primary commodity prices are still at their lowest level since the 1930s.

Debt, in particular, still shackles many developing nations, claiming a large proportion of the resources which might otherwise have been available for investment in human progress. With falling family incomes, and cuts in public spending on services such as health and education, many African and Latin American children are still paying heavily for their nations' debts; and the currency they are paying with is their opportunity for normal growth, their opportunity to be educated, and often *their lives*. With no less urgency than at any time in the last five years, UNICEF must again say that it is the antithesis of civilization that so many millions of children should be continuing to pay such a price (fig. 4).

The better economic news is that projections for the 1990s show the industrialized nations growing at an average 3% per annum and the developing nations growing at just over 5% per annum. Such forecasts, even should they prove accurate, screen great disparities. Most of Asia should see continued steady progress, accompanied by a significant fall in the numbers of the absolute poor. Latin America, the Middle East and North Africa are expected to see slower growth with a smaller reduction in the numbers of the poor. Sub-Saharan Africa, facing rapid population growth as well as economic stagnation and severe ecological problems, will struggle to maintain per capita incomes; without debt cancellation, a renewal of investment, and an increase in real aid, the sub-continent may well see an increase in the numbers living in poverty during the decade ahead.

Development strategy

After 40 years of conscious and often contentious debate about strategies of development, there is perhaps more unanimity on the subject as the 1990s begin than at any previous time. The 1990 World Bank report has summed up the emerging consensus:

"The evidence in this Report suggests that rapid and politically sustainable progress on poverty has been achieved by pursuing a strategy that has two equally important elements. The first element is to promote the productive use of the poor's most abundant asset - labor. It calls for policies that

Pneumonia and diarrhoea: half of all child deaths

Year 2000 goal: A halving of child deaths caused by diarrhoea and a one-third reduction in child deaths caused by acute respiratory infections.

Pneumonia kills approximately 4 million young children a year.

Well-informed parents are the first line of defence. One quarter of pneumonia deaths could be prevented by immunization against measles and whooping cough. Several hundred thousand could be prevented by exclusive breast-feeding for the first four to six months of life.

When pneumonia does occur, early diagnosis and appropriate antibiotics, costing less than $1.00, can prevent the majority of deaths. All parents should know that a child with a cough or cold who is having difficulty in breathing, or is breathing more rapidly than is normal, needs trained help quickly. Thereafter, success depends on the availability of health workers, including community health workers, who can apply simple tests to distinguish pneumonia and, if necessary, administer antibiotic tablets along with clear instructions on how to use them.

The goal of a one-third reduction in pneumonia deaths can therefore be reached by informing parents and by training community health workers, backed up by referral and supervision systems - and by the regular supply of essential drugs.

Diarrhoeal disease also kills approximately 4 million young children each year. Two and a half million of those deaths are a result of dehydration - the draining of too much fluid from the child's body.

Success again depends on the well-informed parent. Diarrhoeal disease can be prevented by breast-feeding, by immunization against measles, by using latrines, by keeping food and water clean and by washing hands before touching food. When a child has diarrhoea, it is essential to keep feeding and to give plenty of the right kinds of liquid, including breast milk, diluted gruels, soup, rice water, or a special oral rehydration solution (ORS). If the diarrhoea persists for more than a few days, or is more serious than usual, trained help is needed.

The second essential is the training of all health workers to know, and to teach, today's methods of coping with childhood diarrhoea - including continued feeding, oral rehydration therapy (ORT), and the use of the special ORS (which costs about 10 cents per sachet and can remedy dehydration in almost all cases).

Today, some form of oral rehydration therapy is used by one family in three in the developing world, and the technique is estimated to be saving over one million lives each year. To reach the year 2000 goal, this knowledge will have to spread to at least three quarters of all families.

Diarrhoeal disease is also a major cause, possibly *the* major cause, of child malnutrition. It takes away appetite and reduces food intake; it reduces food absorption and drains away nutrients; it consumes calories in fever and tissue repair. When the disease occurs up to ten times a year, as is not uncommon among the children of the developing world, then malnutrition is usually the result. It is therefore also essential for parents to know that continued feeding of a sick child, and an extra meal a day in the week or so after the illness, is essential to protect normal growth.

The essential messages to all families can therefore be summed up in the 'three Fs' - Food, Fluids and Further help.

Every year in the developing world, parents spend over $1 billion on mostly ineffective medicines for diarrhoeal disease and respiratory infections - the two most common diseases of childhood and the cause of approximately half of all child deaths. With less money, but more information and training, both diseases can be controlled. Unchecked, they will kill another 80 million children in the 1990s.

harness market incentives, social and political institutions, infrastructure, and technology to that end. The second is to provide basic social services to the poor. Primary health care, family planning, nutrition, and primary education are especially important.

"The two elements are mutually reinforcing; one without the other is not sufficient." *

It is in the second part of this 'two-part strategy for development' that the goals adopted by the World Summit for Children find their place in the overall development effort of the 1990s. For the year 2000 goals are essentially a statement of the most obvious, achievable, and affordable elements in the task of investing in human capacity and providing basic social services to the poor.

The role of aid programmes

This overall context is especially important in considering the role which aid programmes might play in the years ahead.

In this report two years ago, UNICEF proposed that:

"Aid can make it politically easier to take decisions of which the principal beneficiaries would be the poor, the environment, and the future.

"The time has come when not only aid but also debt reduction and trade agreements should form part of a real development pact by which participating industrialized nations would make a commitment to increase resources and participating developing nations would make a corresponding commitment to a pattern of real development which unequivocally puts the poor first.

"The ultimate aim and measure of that real development is the enhancement of the capacities of the poorest, their health and nutrition, their education and skills, their abilities to control their own lives, and their opportunities to earn a fair reward for their labours. This is the kind of development which the majority of people in the poor world seek and the majority of people in the industrialized world would support."

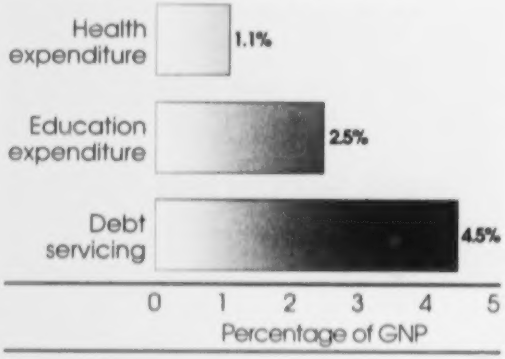
In similar vein, World Bank President Barber Conable has also said: *"The allocation of aid should be more closely linked to a country's commitment to pursue development programmes geared to the reduction of poverty"*.

There could be no better measure of that commitment than progress towards the goals which a majority of the world's political leaders - from both industrialized and developing worlds - have already considered and endorsed.

In this way, the ambitious goals adopted at the World Summit for Children can contribute to the overall development effort of the decade ahead and provide a sharper focus for the industrialized world's aid. And it is in this context that we turn again to the initial question of where the resources might come from to

Fig.4 Health, education, and debt

The chart shows the percentage of Gross Domestic Product devoted to debt servicing as compared to spending on health and education in the 95 low and middle income developing countries during 1987, the latest year for which data are available



Source: World Development Report 1989, World Bank

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* Many of the countries and areas which have made the greatest strides in both economic and human development in recent decades - including Japan, the Republic of Korea, Taiwan, Hong Kong and Singapore - have pursued exactly this strategy, with heavy emphasis from the outset on investment in health and education.

Immunization: a decade of disease reduction

Year 2000 goals: 90% immunization coverage of one-year-olds; 95% reduction in measles deaths; elimination of neonatal tetanus (by 1995); global eradication of polio.

In 1990, measles, tetanus and whooping cough will kill approximately 2.6 million children. In addition, two hundred thousand will be crippled by polio. Immunization against all of these diseases costs approximately $10 per child - including delivery.

Tragic as these figures are, they represent remarkable progress. Just over 10 years ago, when the World Health Organization announced the target of universal child immunization by the end of 1990, fewer than 20% of the developing world's children were immunized. Approximately 5 million children a year were dying from vaccine-preventable disease and half a million a year were being crippled by polio.

For practical purposes, the 1990 goal of universal immunization was taken to mean reaching 80% of the developing world's children before their first birthdays. Today, as the world nears the target date, coverage has risen to almost 80%. As a result, deaths and disabilities from vaccine-preventable disease, which would otherwise have risen with population growth, have been halved. Immunization has therefore been the greatest public health success story of the last decade.

Building on this foundation, all countries should be able to reduce measles deaths by 95%, eliminate neonatal tetanus and eradicate polio in the decade ahead. These extraordinary achievements are now within the grasp of any nation which commits itself to them.

The total cost of approximately $1 billion a year is not prohibitive. Most developing countries could continue to meet over two thirds of the bill, but aid will be needed to meet the expected $300 million a year shortfall.

The investment would soon pay for itself. Smallpox eradication, for example, is today saving the world $1 billion a year in vaccine and surveillance costs - three times as much as the costs of eradicating the disease itself.

In most countries, there are two major opportunities for a rapid and inexpensive increase in coverage during the next few years - and both depend on making better use of already existing facilities. If unvaccinated children who are brought to clinics for other reasons were either vaccinated on the spot or referred for vaccination, and if their mothers were checked for tetanus immunization, then most countries would rapidly reach the 90% target. Similarly, the target would be reached if all children who are brought for a first vaccination were to complete the full course. Drop-out rates between first and third injections are often as high as 50%. Demand for immunization is therefore as important as supply, and the countries which have made rapid progress have used all possible communications channels to promote the immunization message.

Particularly important, as the 1990s begin, is a stepping up of efforts to defeat measles and tetanus.

Measles, the biggest killer among the vaccine-preventable diseases with 1.5 million victims a year, is also a major cause of malnutrition, illness, and vitamin A loss. For this reason, immunization against measles can bring about a reduction of up to one-third in the overall rate of child deaths.

Neonatal tetanus kills some 800,000 infants each year and can be prevented by hygienic delivery methods (clean hands, clean surfaces, clean cutting and dressing of the cord) and/or by immunizing all women of child-bearing age (preferably before pregnancy). Progress against tetanus lags behind in most nations.

After smallpox eradication in the 1970s, polio is likely to be the next major disease to be eliminated. Latin America and Europe should achieve that goal by 1995 and the rest of the world by the year 2000.

fund this investment in today's children - and tomorrow's world.

Finding the resources

It is virtually impossible to calculate the overall financial cost of reaching all of the goals adopted at the World Summit for Children, though some individual estimates are made in the various panels of this report. But for the sake of bringing the cost into overall perspective, a 'best guess' would put the figure close to $20 billion a year for the next decade. The cost will vary enormously from county to country, but a very approximate global breakdown by mid-decade would be:

Approximate annual cost (by mid-decade) of reaching the year 2000 goals

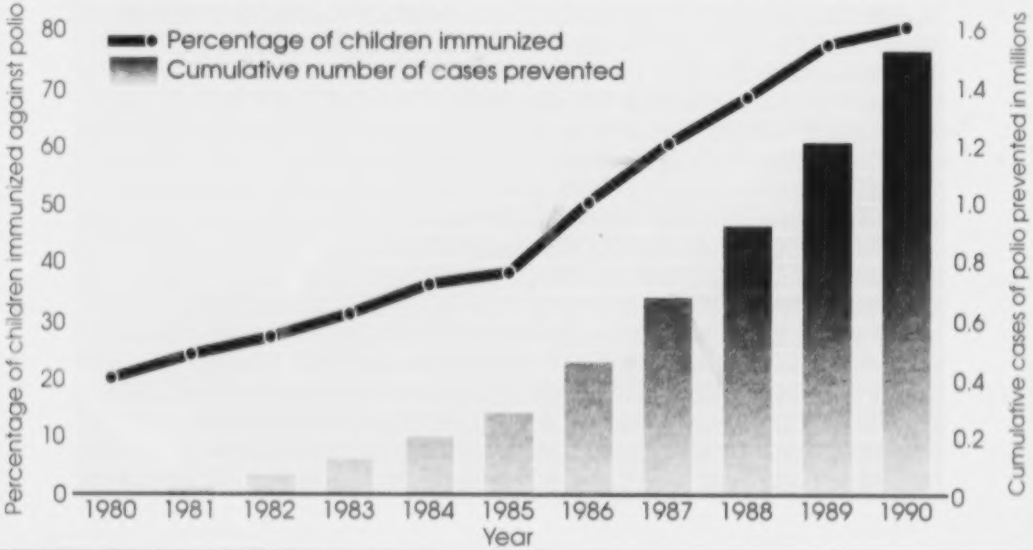
Health goals	$3 billion
Nutrition goals	$3 billion
Education goals	$5 billion
Water and sanitation goals	$9 billion

To put this $20 billion a year into perspective, it is approximately one eighth of one per cent of the world's annual income. It is half as much as Germany will find for the process of national reunification in 1991. It is as much as the world spends on the military every 10 days. "*The financial resources required are modest*", says the Plan of Action adopted at the Summit, *"in relation to the great achievements that beckon.*"

Fig.5 The prevention of polio, 1980-90

The chart shows the growth in the percentage of the developing world's children who are immunized against polio, and the cumulative number of cases of polio thereby prevented, during the decade of the 1980s.

This effort means that there are now over one and a half million children growing up normally in the developing world who would have been crippled by polio were it not for the immunization programmes of the last 10 years.



Source: WHO and UNICEF

Such comparisons are made almost every year in *The State of the World's Children* report. And they are made here again because it must never become accepted as normal and unremarkable that a fifth of mankind should be without adequate food, safe water, basic health care, and elementary education, or that millions of children should die or be stunted in brain and body, in a world which clearly has the knowledge and the resources to enable all its people to meet their own and their children's needs. However ritualistic such comparisons may seem, they serve to make a mockery of the idea that the world cannot yet afford to contemplate the great step forward for our civilization which would be represented by achieving the year 2000 goals and bringing basic protection to the lives and the growth of all its children.

But it is equally clear that such comparisons do not mean that $20 billion a year will be forthcoming for this purpose. On a practical basis, where might the money come from?

Overall, the developing countries will probably have to find about two thirds of that sum themselves*.

The two major internal sources of such sums are the restructuring of present spending *in favour of the social sector* and the restructuring of present spending *within the social sector*.

To take the first of these, more than 25% of all present government expenditures in the developing world are devoted to the military, to inefficient state-controlled companies, and to subsidies which are not targeted to those most in need. Military spending is the greatest of these. The developing nations as a whole are now spending more on the military than on education and health combined*. With the ending of the cold war and the easing of regional tensions, it cannot be too unrealistic to suggest a 5% cut in defence spending - which would in itself liberate half of the estimated $20 billion a year needed to reach the year 2000 goals.

'New' resources could also be found within the amounts which are already allocated to social services. In health, hospitals which reach at most 15% to 20% of the population often claim 80% of the budget. In education, more than half of all government spending is often allocated to secondary and higher education for the minority, usually from higher-income families. In water and sanitation schemes, 80% of the $10 billion now being invested each year is being devoted to schemes costing $550 or more per person, while less than 20% is being allocated to today's low-cost strategies costing less than $30 per person served. Relatively modest spending shifts from high per capita cost services, which generally serve the relatively better off, to low per capita cost strategies for the poor could therefore release enough to meet the developing world's share of the overall bill.

External aid

Approximately one third of the $20 billion needed might be expected to come from the industrialized world. And that contribution of an extra seven billion dollars a year could be made in many different ways.

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* Many have suggested that there is considerable scope in asking poor communities themselves to pay part of the cost of basic health and education services. The Bamako Initiative, for example, plans to make essential maternal and child health services available throughout sub-Saharan Africa partly by means of community control and financing. Although this would involve many families in paying for services, the annual costs will be less than most families are already paying for privately purchased drugs and medicines (most of which are ineffective). Similarly, many millions of poor families are already paying more to water vendors for water of dubious quality from trucks or carts than would be needed to finance piped water supplies to their communities. There is undoubtedly scope and value in some kinds of user charges and community financing. But it is a decision which needs to be made sensitively and knowledgeably at the local level, for there is a distinct danger that such a policy may make even more difficult the task of reaching the unreached - the poorest 20% of families who are so frequently bypassed even by the health and education services which are available.

* This overall figure for the developing world hides wide regional disparities. Most Latin American nations, for example, spend less on the military than on health and education and many Middle Eastern countries spend considerably more.

First, debt relief might be specifically linked to investments in reaching the agreed goals. Seven billion dollars is, after all, only as much as the industrialized world now receives from the developing world in debt repayments *every 10 days*. As the Plan of Action adopted at the World Summit for Children urges:

"*Debt-relief schemes could be formulated in ways that the budget reallocations and renewed economic growth made possible through such schemes would benefit programmes for children. Debt relief for children, including debt swaps for investment in social development programmes, should be considered by debtors and creditors.*"

Increases in aid are another possibility; but more efficient use could be made of the $50 billion a year currently allocated. At the moment, far less than 25% of all the industrialized world's bilateral official development assistance is devoted to health and education, and this proportion has fallen by about 30% over the last decade.

Fig.6 Proportion of ODA going to basic health and education, 1986-87

Less than 25% of the industrialized world's aid is devoted to health and education, and this proportion has fallen by about one third over the last decade. Three of the most basic elements of human development – primary health care, primary education, and rural water supply and sanitation – receive only just over 3% of all aid.

Allocation of official development assistance (ODA) 1986-87

Health (inc.family planning)	**5.0%**
Primary health care	**1.5%**
Education	**11.0%**
Primary education	**1.0%**
Water and sanitation	**6.0%**
Rural water and sanitation	**1.0%**

Source: OECD/DAC 1989. Figures based on detailed sector reporting from OECD Credit Reporting System Data Base (which covers bi-lateral technical assistance only partially)

Within this small and shrinking slice of the aid pie, it is again the higher cost services for the relatively better off which take the greater part. Aid for primary health care, including family planning, primary education, and rural water supply and sanitation, totals only just over 3% of the industrialized world's aid (fig 6).

It would therefore require less than drastic changes in the orientation of existing aid programmes to release the resources needed to support the year 2000 goals. Even if only the projected *increases* in aid over the next few years were devoted to primary health care, primary education, and low-cost water and sanitation schemes, then the annual amount of aid available for these purposes would be *doubled**.

Ideally, the process of making these relatively small shifts in spending - both in developing country budgets and in the industrialized world's aid budgets - would be a co-operative effort. Few changes could make the achievement of the year 2000 goals more likely than a series of compacts by which one or more developing countries made agreements with one or more industrialized countries on adequately funded plans for making measurable progress towards those goals.

As the Plan of Action adopted at the World Summit for Children recommends:

"Each country is urged to re-examine in the context of its particular national situation, its current national budget, and in the case of donor countries, their development assistance budgets, to ensure that programmes aimed at the achievement

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* Differences between the industrialized nations have also become more marked in recent years. Canada, Denmark, Finland, the Netherlands, Norway and Sweden, contribute roughly twice as much aid per capita as most industrialized countries, and their aid programmes are generally more biased towards basic services and poverty alleviation. If all aid-giving nations were to move in this direction, then the resources required to meet the year 2000 goals would quickly be subscribed.

Child survival: and population growth

"The surest way to achieve a sustained decline in fertility is to give a new priority to 'social' or 'women's resources' investment, to improving mother and child health, women's status and education and to making family planning as widely available as possible to both women and men."

The State of World Population 1990,
Dr. Nafis Sadik, Executive Director,
United Nations Population Fund

Doing what can now be done to reduce child deaths in the developing world would also help to slow population growth. Some of the reasons:

The physiological factor

An infant death means the end of breast-feeding, an important 'natural contraceptive'.

The replacement factor

The death of a young child prompts many couples to replace the loss of the child by a new pregnancy. Studies in Bangladesh show that an infant death reduces the average interval between births from more than three years to less than two. Families which experience the death of a child are much less likely to use any method of birth planning.

The insurance factor

When child death rates are high, parents often insure against an anticipated loss by having more children. Planning on the basis of the worst that can happen, rather than on the basis of statistical probabilities, often means over-compensation and an average family size greater than desired.

The confidence factor

Empowering parents with today's child survival knowledge helps build the confidence which is so crucial a factor in the acceptance of family planning. As the UN Population Division has concluded, "Any given improvement in mortality will be more likely to initiate fertility control behaviour among those who understand and participate in that improvement than among those who do not".

The direct effect of child survival strategies

Three of the most important means now available for reducing child deaths are also among the most powerful means of reducing birth rates:

○ Promoting the knowledge that children can be protected by exclusive breast-feeding for the first four to six months will also help to lower birth rates, because breast-feeding is one of the most effective ways of preventing pregnancy during that period.

○ Most child deaths happen to mothers who are younger than 18 or older than 35, who have had more than four children already or who give birth less than two years after a previous delivery. Promoting knowledge about the importance of timing births, and providing the means to act on it, is therefore one of the most powerful child survival strategies - and also reduces birth rates.

○ Female education, in addition to the advantages it can bring to women, improves child health and survival. Educated mothers are also more likely to opt for smaller families.

The synergism between this array of child survival actions and effective family planning programmes means that the two together can bring about population stabilization at an earlier date and at a lower level than either acting alone. The 1990s offer a remarkable opportunity to use this synergism, as many developing countries are now at the critical 'point of parental confidence' where further reductions in child deaths are likely to bring even greater reductions in births.

The experience of individual countries shows the power of this combination. If all countries were to achieve the same under-five death rates and the same birth rates as Chile or Sri Lanka, for example, then the world would see approximately 10 million fewer deaths each year - and approximately 20 million fewer births.

of goals for the survival, protection and development of children will have a priority when resources are allocated. Every effort should be made to ensure that such programmes are protected in times of economic austerity and structural adjustments."

If the promise of the World Summit for Children is to be kept, then this re-examination of spending priorities in both industrialized and developing worlds will need to be completed no later than the end of 1991.

The principles of success

Adequate finance is a necessary but not sufficient condition for progress towards the year 2000 goals. Investment in human capacity, the 'second part' of a two-part development strategy, is not simply a question of spending money. It has its own difficulties, and requires its own strategies.

Those strategies will be complex and diverse as each country chooses its own mix of priorities. But all involved in the immunization effort of the last 10 years have learnt a great deal about the question of *how* ambitious goals can be achieved. What follows is an attempt to summarize some of the guiding principles of that success.

The need for accepted goals

The first lesson to be learned is the importance of goals themselves - of setting targets and regularly monitoring progress towards them (see panel 18 for a brief description of the year 2000 health goals which the United States has set for itself). Targets serve as a focal point for management by objectives, as a unifying concern for all who must collaborate in such an enterprise, and as a rallying point for public awareness and for maintaining the necessary political pressures.

For the health and education services, attainable targets can help development efforts to go to scale, to go beyond the trials and the pilot schemes which have illustrated that success is possible and to address the more diffuse and difficult question of putting known solutions into action on the same scale as the problems.

The goal of universal child immunization, for example, has begun to achieve, in some parts of the world, an essential transformation in the very concept of what health services are and what they do. In trying to reach 80% of all infants, many health service workers at all levels have begun to think of the population to be served not as those who walk through clinic doors but as the total population of a given area. The concepts of enumeration and accountability, of reaching out to the unreached, of working within a complex and interdependent system to achieve a common end - all of these have begun to be strengthened by the effort to reach the immunization target. And all of these concepts are essential for the achievement of the goals which have now been set for the year 2000.

To fulfil these functions, and to attract the necessary breadth and depth of support, it is

Timing births: education and services for all

Year 2000 goal: Family planning education and services for all.

Every year, half a million young women die from causes related to pregnancy and childbirth. Every year, more than 14 million children die before reaching the age of five. Many of those deaths occur when births are more than four in total, or are closer together than two years, or are to women who are younger than 18 or older than 35. In the 1980s, more detailed analyses of this relationship have revealed that if all births were spaced at least two years apart, then this one change alone would reduce maternal deaths by perhaps 30% and child deaths by approximately 20%, and bring about a significant reduction in child malnutrition.

Even if there were no such thing as a population problem, informing people about the importance of timing births and providing culturally acceptable methods of family planning would therefore be one of the most important of human priorities for the 1990s.

At present, the proportion of couples who are using some form of preventing unwanted births is approximately 75% in China and East Asia, just over 50% in Latin America, about 30% in South Asia and less than 15% in Africa.

In many other areas of public health the need to create demand is one of the most difficult obstacles. But in the case of family planning, a demand already exists. More than one third of the women in the developing world who have given birth in the last 12 months did not want to become pregnant. And there are today an estimated 300 million couples who do not want any more children but who are not using any effective means of preventing pregnancy. If that demand were to be met during the decade ahead, then several major gains for humanity would be made at very low cost:

○ A steep reduction in the more than 100,000 illegal abortions which are now performed *every day of the year* and in the 500 deaths of young women which are the *daily* result.

○ A sharp reduction in maternal mortality and a significant improvement in the health of many millions of women, who would be relieved of the physical and mental burdens of having too many children too close together, or at too early or too late an age.

○ An immeasurable improvement in the lives of children. Not only would child death rates fall, perhaps by as much as 20%, but the quality of child care, of health, nutrition and education would rise as parents were able to invest more of their time, energy and money in fewer children.

○ Population growth would be slowed. If women could control the number and timing of births, then the rate of population growth in the developing world would fall by an estimated 30%. One generation from now, total world population would be approximately 20% or 1.3 billion people *less* than is currently projected. The struggle against poverty would be facilitated and environmental pressure would be alleviated.

With so many advantages to be had from the meeting of an existing demand at an affordable cost, the year 2000 goal of making the knowledge and the means of timing births available to all is one of the most cost-effective investments which the human race could possibly make in both its present and its future well-being.

essential that the goals themselves should be universally known and accepted. World-wide interest must be awakened; ambitions must be stirred; expectations must be aroused; and commitments from all possible sources of support must be made and sustained.

In particular, the personal and political commitment of a nation's leaders is usually necessary for sustained progress on a nation-wide scale. Presidents and Prime Ministers can ask for regular reports on immunization levels, school completion rates, and on the progress of today's low-cost solutions to basic health problems. They can call upon those who control the major channels of communication to promote today's vital health knowledge and to bring about an information revolution for the poor. They can make it clear that inexpensive but essential services for the majority should be given a high priority in government spending. They can initiate new data collection systems and insist that the growth of their nations' children should be as regularly and carefully monitored as the growth of their economies. And in the industrialized world, political leaders can review aid programmes in order to give a new priority to basic services for the poorest - and they can commit their governments to that same principle at home.

The World Summit for Children, which was the culmination of a long process of consultation with governments and technical experts from all regions, has given a flying start to this process of establishing the year 2000 goals. But the declarations and commitments of political leaders are not enough. Goals must become the goals of society as a whole; and it is essential that, within the next few months, all organizations and individuals who share the dream of a world without preventable malnutrition and disease, a world which protects the lives, the growth, and the rights of its children, should also consider what part they might play in entrenching the year 2000 goals and in enlisting sustained support for them over the decade ahead. The Plan of Action adopted by the World Summit for Children specifically asks all national, regional, and international organizations, governmental and non-governmental, to "*examine how they can contribute to the achievement of the goals and strategies enunciated in the Declaration and this Plan of Action as part of more general attention to human development in the 1990s. They are requested to report their plans and programmes to their respective governing bodies before the end of 1991 and periodically thereafter.*"

Some of the greatest successes in immunization over the last few years have been brought about by involving a wide range of a society's resources - its media, its schools, its religious institutions, its businessmen, its non-governmental organizations, as well as its government services and health professionals. As the Plan of Action noted: "*The experience of the 1980s shows that it is only through the mobilization of all sectors of society, including those that traditionally did not consider child survival, protection and development as their major focus, that significant progress can be achieved in these areas.*"

Similarly, almost every organization and individual can play a part in helping to sustain the political commitments made at the Summit. This will, in the end, be the make-or-break issue. For the poor are not usually poor by accident; they are poor because they are relatively powerless, because their voice is not sufficiently heard or heeded in the selection of society's priorities or in the allocation of its resources. A political commitment which is first and foremost a commitment to the poor is therefore a commitment which, even if made with the utmost sincerity and the best of intentions, is in danger of putting down only shallow political roots.

Those roots will obviously be deeper where democracy is stronger. But we are not living in an ideal world: in every country, rich and poor, an enormous effort will be needed to keep up the political pressure, to keep faith with the promises that have been made, and to so commit societies to the year 2000 goals that failure to live up to them will become no less than a matter of national and international shame. A sustained political commitment is the *sine qua non* of achieving those goals. And that political commitment is ultimately a matter not only for politicians but for us all.

The infrastructure

Another essential factor is the availability of low-cost technologies and strategies which reduce the costs involved and therefore the political will required. Goals must not only be technically possible but also politically and financially feasible. Much careful thought has already been given to this matter in the selection of the year 2000 goals, and the available techniques and strategies are discussed in the panels on the left-hand pages of this report.

The more difficult question today is the means by which today's knowledge and technique can be put at the disposal of the majority. Many of the year 2000 goals are dependent on the delivery of low-cost *technologies* - be they vaccines, oral rehydration salts, antibiotics, growth charts, iron tablets or vitamin A supplements. Many also depend on the delivery of *knowledge* which can empower families themselves to take more control over their own health: today's knowledge about the importance of birth spacing, about special care in pregnancy and childbirth, about the importance of breast-feeding, about safe ways of weaning, about promoting normal growth, about preventing and coping with common illnesses, and about preventing the spread of AIDS - is knowledge which every family, and not just every health worker, should have (panel 12).

Most of the year 2000 goals depend on the combination of both - on trained help and appropriate technologies and on empowering families with knowledge. The question of infrastructure, of the capacity to deliver, can therefore be considered in two overlapping parts.

The immunization effort could not have reached three quarters of the developing world's children without a minimum infrastructure of health services capable of delivering the right vaccines at the right temperature in the right quantities and at the right times to some 80 million children a year. This halting and incomplete progress towards an infrastructure of health is one of the most important advances of recent years - and it makes it possible to think of putting the benefits of today's knowledge and technique at the disposal of all.

The immunization effort itself has, in many places, strengthened this system, but achieving the goals for the year 2000 will require a very considerable further strengthening, including more investment in management skills, training, supervision, and referral systems.

In particular, it is the effective community health worker who can enable families to use today's knowledge for the improvement of their own and their children's lives. With a few months' basic training, supported by referral and supervision systems, a community health worker can offer advice and practical help with such things as birth spacing, pre-natal care, safe delivery, breast-feeding, weaning, feeding a child during and after illness, growth monitoring, disease prevention, immunization, oral rehydration therapy (fig. 7 and panel 5), the use of antibiotics against acute respiratory infections, and the distribution of vitamin A capsules, iron supplements or malaria tablets. *Such information and such techniques constitute a large part of what is required to meet the year 2000 goals of reducing child deaths by one third and child malnutrition by half* (panels 2 and 4). Yet the job can largely be done by community health workers who can be trained for as little as $500 (as opposed to fully qualified doctors whose training may cost $70,000 or more). It is therefore reasonable to assume that those countries which succeed in reaching the goals for the year 2000 will be those countries which also succeed in putting a well-trained, well-supervised, and well-supported community health worker within reasonable reach of every family.

The communications capacity

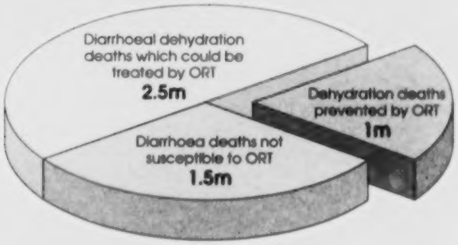
The other half of the 'infrastructure' question is a country's capacity to put new knowledge at people's disposal. And here, too, recent years have seen advances which could amount to nothing less than an information revolution *for*

Fig.7 The spread of oral rehydration therapy (ORT)

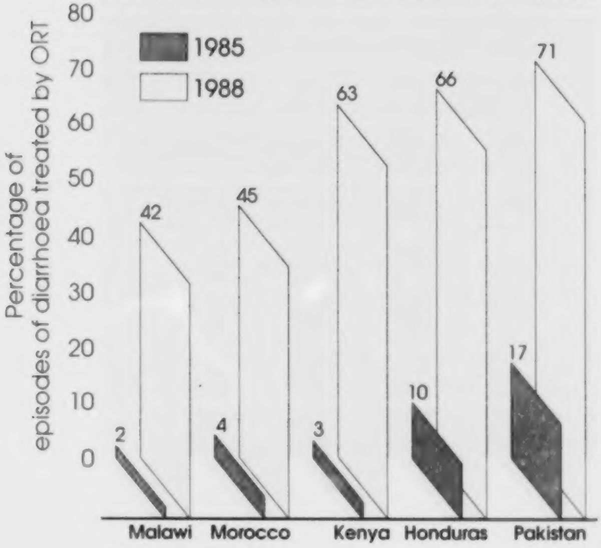
ORT is an inexpensive method of preventing and treating the dehydration, caused by diarrhoeal disease, which is the single most common cause of death among the world's under fives. The technique was almost unknown a decade ago. It has been taught to almost one third of the developing world's families in the 1980s.

Deaths prevented by ORT

Diarrhoeal disease: estimated annual deaths prevented and still occuring, developing countries (excluding China), 1988



Gains in ORT use, selected countries, 1985–88



Source: WHO and UNICEF estimates.

the poor. Rising literacy and the growth of newspapers, the spread of radio into almost every home and television into almost every community, the popularity of cinema and more recently the video theatre, the new outreach of religious leaders, the rise of the numbers enroled in school, the proliferation of non-governmental and voluntary organizations, the growth of professional societies, employers' associations, trade unions, and government services all mean that the capacity of the developing world to communicate with the majority of its people has been transformed. The task that remains is the mobilization of this new capacity in order to empower people with today's knowledge (panels 10 and 12). "*All forms of social mobilization*", says the Plan of Action adopted at the World Summit, "*including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children.*"

In this sense, therefore, the question of whether or not the year 2000 goals can be achieved, whether or not the promise can be kept, is a question not just for governments but for the mass media, for the schools, for the churches, temples and mosques, for business and commerce, for the professional associations and the academic community, for the non-governmental organizations and the women's movements, for the employers' associations and the trade unions, for the youth organizations and the sports and entertainment industries.

In short, the question of whether the promise will be kept is a question for us all.

Monitoring and disparity reduction

Mention has already been made of the need to monitor progress towards the declared goals. But even this will not be an easy task. In most countries it is still easier to find out how many video recorders have been imported in the last 12 months than it is to find out how many children have died, or what percentage have been immunized, or have access to clean water,

Breast-feeding: reversing the decline

Year 2000 goal: All mothers to be informed and assisted in successful breastfeeding.

Reversing the decline of breast-feeding in the developing world could save the lives of an estimated 1.5 million infants every year. Bottle-fed babies, who are often given powdered milk over-diluted with unsafe water in unsterile bottles, are several times more likely to die in infancy. Breast milk is the complete nourishment, safe, hygienic, inexpensive, and helps fight common infections.

But as families move into cities, as women join the work force, and as mothers are subjected to advertisements for commercial baby foods, so bottle-feeding is perceived as the modern way, and breast-feeding as old-fashioned and inconvenient.

In the industrialized world, after a steep decline, there is today a pronounced trend back towards breast-feeding. A similar decline in the developing world, where bottle feeding entails much greater risks, would lead to millions of infant deaths.

All mothers should therefore know, and be helped to put into practice, five basic facts.

1 Breast milk ALONE is the best possible food and drink in the first four to six months of life.

2 Virtually every mother can breast-feed her baby. Babies should start to breast-feed as soon as possible after birth.

3 Frequent sucking is needed to produce enough breast milk for the baby's needs.

4 Bottle-feeding can lead to illness and death.

5 Breast-feeding should continue well into the second year of a child's life.

Breast-feeding mothers also need the moral and practical support of husbands, family, other mothers, health workers, employers and, more broadly, of the education system and the mass media.

In particular they need two specific kinds of support which governments can provide.

First, the irresponsible promotion of powdered milks should be stopped, in all countries which have not yet done so, by applying the internationally agreed code on the marketing of breast-milk substitutes. The main points of the code are:

- No advertising of breast-milk substitutes, bottles, or teats, to the public.
- No free samples to mothers or promotion of products inside health care facilities.
- All labels to explain the risks.

Second, national health services can ask all maternity units to follow the WHO/UNICEF 'ten steps to successful breast-feeding'. The advice given to mothers in maternity wards is probably the most important single influence.

A summary of the ten steps:

- Have a written breast-feeding policy routinely communicated to all staff.
- Train all staff in making the policy work.
- Inform all pregnant women about the benefits of breast-feeding.
- Help all mothers begin breast-feeding within an hour of giving birth.
- Show mothers how to breast-feed successfully.
- Give new-borns no food or drink other than breast milk unless medically necessary.
- Allow mothers and new-born infants to stay together 24 hours a day.
- Encourage breast-feeding on demand.
- Give no dummies or pacifiers.
- Foster mothers' support groups and refer new mothers to them.

In addition to the savings in children's lives and health, breast-feeding also offers financial savings to both parents and health services. Respiratory infections and diarrhoea are the most common infant illnesses in almost every developing country, accounting for over 50% of visits to clinics and hospitals.

or are enroled in school. If the goals are to be achieved, then it is a matter of urgency that systems of data collection be improved before the end of 1991. "*Each country should establish appropriate mechanisms*", says the Plan of Action adopted at the Summit, "*for the regular and timely collection, analysis and publication of data required to monitor relevant social indicators relating to the well-being of children - such as neonatal, infant and under-five mortality rates, maternal mortality and fertility rates, nutritional levels, immunization coverage, morbidity rates of diseases of public health importance, school enrolment and achievement and literacy rates.*"

Monitoring every five years has been shown to be not enough. Progress should be monitored at least annually. And the results should be as widely commented on by the media as are statistics on economic growth, inflation, and the balance of payments. It is essential that political leaders are, and are seen to be, concerned about progress, or the lack of it, towards the stated goals. But again, monitoring should be the concern not only of political leaders but of society as a whole, and particularly of its news media.

Finally, it is becoming increasingly important for the monitoring process to avoid the fallacy of the average.

Average levels of immunization coverage, educational achievement, or under-five mortality, can and do mask serious disparities of many kinds - between boys and girls, between urban and rural, between different regions of a country, between different ethnic or cultural groups, and especially between different economic strata of society. A national immunization level of 75% can mean 95% for urban children and 65% for rural children. A national primary school enrolment rate of 80% can mean 100% of boys and 60% of girls. A national under-five mortality rate of 50 can mean 30 for the majority in the mainstream of the nation's life and 150 among the ethnic minorities, the geographically isolated, or the politically disenfranchized.

The monitoring of averages tends to become less sensitive as those averages rise. And a monitoring system which fails to take disparities into account risks becoming a blunt instrument for the inducement of complacency rather than a spur in the right direction.

As averages rise, the monitoring process should therefore focus more on measuring how many fall how far below the average, and on identifying who they are, where they are, and why they are being marginalized by progress. This is the kind of monitoring which can help to raise average levels towards declared targets not by bringing about improvements for those who are already at or above the mean but by reaching out to those who, for whatever reason, fall below. This kind of monitoring is more likely to lead to a reaching-out to the unreached - to the girls and the women, to the illiterate and the unconfident, to those who are socially and culturally discriminated against, to the poorest and the most disadvantaged.

This task of monitoring disparities will not necessarily be politically popular or administratively easy. Yet as Karl-Eric Knutsson, UNICEF regional director for South and Central Asia, has said this year:

> *"If we do not dare again to raise the central issue of equity in development, if we do not dare to face boldly the need to reach the poor and the difficult to reach, our work will be in danger of becoming increasingly irrelevant to those we most seek to support."*

Education for all: by the year 2000

Year 2000 goals: Basic education for all. Halving adult illiteracy. Ending male/female disparities.

After almost four decades of rapid advance, the idea of education for all has now been brought to a halt, in many nations of the developing world, by the debt crisis and consequent cuts in government spending. *"The past few years"*, says UNESCO Director-General Federico Mayor, *" have witnessed an unprecedented halt in the growth of basic educational services and a stagnation and deterioration of educational quality... In nearly half the developing countries the goal of universal primary education is now receding rather than drawing nearer."*

The overall position in 1990 is that approximately 100 million 6 to 11-year-olds are not attending school (60% of them girls) and one in four adults in the world - almost a billion people - cannot read or write (two thirds of them women).

Against this darkening background, the *World Conference on Education for All* opened in Jomtien, Thailand, in March 1990. Sponsored by the World Bank, the United Nations Development Programme, UNESCO and UNICEF, the Conference brought together almost 2,000 education leaders from over 150 countries to try to find ways and means of reaccelerating progress.

As many delegates to Jomtien pointed out, there is still an intimate connection between whether the burden of debt is reduced or not and whether children go to school or not. But it was also widely agreed that school enrolment and literacy could be improved, even within existing budgets, by a relatively small tilt in spending to favour primary schools for the many rather than higher education for the few. Dollar for dollar, investments in primary education not only yield greater equity but also greater economic returns. By the same token, aid for education also needs rethinking. At present only 1% of all the industrialized world's educational aid goes into primary education.

In addition to a new priority for primary schools, new strategies could also stretch existing resources to reach more children. A new kind of primary school in Bangladesh, for example, is now bringing basic education - literacy, numeracy and essential life skills - to over 100,000 children aged 8 to 10 in rural areas. The 4,000 schools established so far use classrooms built by the local community and teachers recruited from the better-educated members of the village. Until universal primary education of a more conventional kind is achieved, variations on such strategies could form an effective temporary bridge to prevent literally hundreds of millions of children from falling into illiteracy and failing to acquire basic life skills in the decade ahead.

Third, basic education could be boosted by mobilizing today's communications capacity - the mass media, the religious and voluntary organizations, the business community, the health and social services, and people's own organizations. By using every available channel for putting today's knowledge and practical life skills (about such issues as family health, food production and environmental protection) at the disposal of all families, this alliance of social resources could prove to be as useful to the cause of basic education in the 1990s as it has been to the cause of universal immunization in the 1980s.

By such strategies, concluded the Jomtien Conference, it should be possible to reaccelerate progress and achieve three basic educational goals by the end of the 1990s. First, basic education for all, bringing literacy, numeracy and essential life skills to the great majority of the children of the 1990s. Second, reducing the adult illiteracy rate to half of its 1990 level. Third, ending the great disparities in education between boys and girls.

The estimated cost of achieving universal primary education is an additional $5 billion per year over the decade of the 1990s.

A new ethic for children

Targets and strategies alone will not achieve the year 2000 goals. All significant social change - be it the abolition of slavery, the spread of democracy, the end of colonialism, the discrediting of racism and apartheid, the advent of a new respect for the environment, or the struggle for female equality - has both required and stimulated a change in the prevailing ethical climate. Socrates thought slavery was normal; Churchill thought it right for Britain to control the destinies of Africa and Asia; Dr. Johnson laughed at the notion that a woman could deliver a speech in public; Benjamin Franklin was given to the curious opinion that Finns and Swedes were generally darker-skinned than the English and therefore slightly inferior; and the first chairman of the company that is now Mercedes-Benz believed that only a small minority of the working class could ever be taught to drive a motor car.

These were all honourable men who shared the conventional wisdom of their times.

Bringing about a change in the ethical climate in which such opinions flourished was, and in many cases still is, the most difficult part of the long struggle for a more just society. It may be argued that changes in the pattern of economic vested interests, and the struggles of the oppressed themselves, have been the more important forces; but neither pre-empts the need for a fundamental change in what society deems to be normal, acceptable, and right. "*I am sure*", said Keynes, "*that the power of vested interests is vastly exaggerated compared with the gradual encroachment of ideas.*"

The goal of ending mass child deaths and mass child malnutrition, and of providing basic protection for the lives and the normal development of all children, is as difficult and significant a social change as any of the great changes that have gone before. And this dream, too, will be realized only with the wide acceptance of a new ethic for children.

The essence of a new ethic for children is the principle referred to in the Plan of Action adopted by the Summit as "*the principle of a 'first call for children' - a principle that the essential needs of children should be given high priority in the allocation of resources*".

The need for that new ethic arises, as ethics usually do, from practical as well as moral roots. The special vulnerability and the special responsiveness of the early years, demand that the child's one chance for normal growth should be given a *first call* on our concerns and capacities.

Those same reasons also demand that children should be able to count on that commitment in good times and in bad - in lean times and in times of plenty, in times of peace and in times of war, in times of recession or in times of steadily advancing prosperity. The mental and physical growth of a child cannot be asked to wait until interest rates fall, or until commodity prices recover, or until debt repayments have been rescheduled, or until the economy returns to growth, or until after a general election, or until a war is over. The ethic of first call for children does not demand that protection for the lives and the development of the young should be a priority; it demands that it should be an absolute. It does not demand the kind of commitment which can be superseded by other priorities that suddenly seem more urgent, but the kind of commitment that will not waver in the winds of change which will always blow across the world of human affairs.

There will always be something more immediate. There will never be anything more important.

In the past, it may often have been inevitable that the physical, mental and emotional development of children should be exposed to the slings and arrows of adult society. But in our time, for the first time, we have the chance to begin shielding the lives and the normal growth of children from the worst excesses, misfortunes, and mistakes of the world into which they are born. And the fact that our societies do not now do so will one day be regarded as being as strange and uncivilized as is the notion of slavery today.

All of this is directly relevant to the accomplishment of the goals which the world has now set for its children in the years ahead. For the principle of first call would demand that whether a child survives to adulthood, whether a child grows normally in mind or body, whether a child is well nourished, has health care, is immunized, has a school to go to, should not, by the year 2000, have to depend on such things as the balance of payments, or on the level of interest rates, or on fluctuations in the terms of trade, or on the election of any particular political party, or on any other of the inevitable turbulences of the adult world.

Like other great changes in prevailing ethic, the world-wide acceptance of this principle of first call for children will not come quickly or easily. But like other such changes, it will represent nothing less than an advance for civilization itself.

Africa and Latin America

In every region, the children of the 1990s are, in different ways, crying out for a first call on their society's concerns and capacities, and on those of the international community as a whole.

Over much of Africa and Latin America, what has happened to millions of children over the last few years has been the result of a prevailing ethic which is almost the exact opposite of this principle. In many nations, children have been allowed to suffer first and most, not last and least, from the effects of the debt crisis and of economic adjustment programmes. Had the principle of first call been widely accepted during these years, both in national and international society, it would have been possible to maintain the commitment to children even in the most difficult of times. When former President Julius Nyerere asked, "*Must we starve our children to pay our debts?*", he should have been answered, by both developing and industrialized nations, with a resounding 'no'. Debt relief and well-targeted assistance could have been organized in order to specifically avoid the cuts in services and subsidies which have undermined children's nutrition, health care, and education. But in practice, the question was answered by a deadly silence.

Within developing countries, adjustment policies could have been designed so that social spending did not suffer the deepest cuts. And within social budgets, hospital building programmes could have been postponed to keep rural clinics supplied with essential drugs; spending on higher education could have been held in check to keep primary schools open; the savings that had to be made could have meant cancelling the purchase of new weapons systems rather than cancelling the subsidies on staple foods. And conscious and closely monitored action could have been taken - with the support of the industrialized nations - to make sure that adjustment policies did not mean the sacrifice of children's growth, health, and opportunity to be educated.

Today, the need to make specific provision for the most vulnerable, including children, during the process of adjustment is becoming widely recognized and has been explicitly endorsed by both the World Bank and the International Monetary Fund. But in practice, even the specific steps which have been taken are designed primarily to compensate for the ill effects of adjustment policies rather than to protect and improve the health, nutrition, and education of the poorest and the most vulnerable. The human development goals adopted for the 1990s should now become guidelines for adjustment policies, as of development policies, in the decade ahead.

First call in Asia

Several Asian countries and regions, including Japan, the Republic of Korea, Taiwan, Hong Kong, and Singapore, and more recently Indonesia, Thailand and Malaysia, have convincingly demonstrated that a development strategy which includes investments in people - in their health, nutrition, and education - can contribute to rapid economic growth. But for many of Asia's larger and poorer nations, most of which have managed to avoid the worst of the debt trap and sustain steady economic growth over the last decade, human development still stands as a question mark over the

1990s. For just as the principle of first call asks that conscious and specific action be taken to ensure that children are the last to suffer from economic set-backs, it also asks that action be taken to ensure that children are among the first to benefit from economic advance.

Despite slowly rising per capita incomes, poverty still finds its centre of gravity in Asia. Thirty per cent of all the children who die each year, 30% of all those who are not immunized, and 40% of those who are malnourished, are to be found in just three countries - Bangladesh, India and Pakistan. This is not only a function of the sheer size of Asia's populations; the *percentage* of children who are malnourished in south Asia is almost twice as high as in Africa. The *prevalence* of low birth weight, a sensitive indicator of the well-being of women, is also more than twice as high in Asia as in any other region of the world. Even in China, where so much has been done with so little, the prevalence of malnutrition among the under-fives is hardly different from that of sub-Saharan Africa (fig. 8).

The 1990s should see continued economic growth and continued reductions in overall poverty throughout most of Asia. If the decade were to also see a new commitment to the principle that basic protection for children should be one of the first fruits of that growth, then Asia should be able to make a very significant change in the figures just cited - and a very significant investment in its own future.

The children of the industrialized world

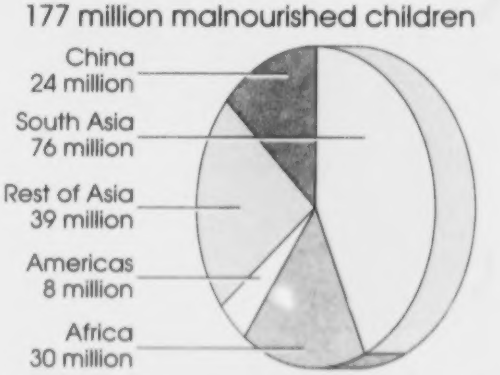
The principle of first call for children has just as far to travel in the industrialized world.

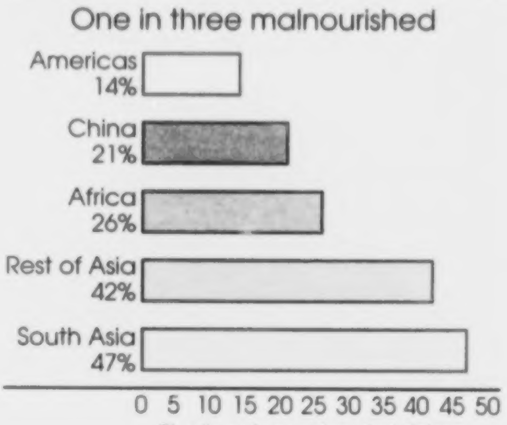
Despite generally rising prosperity, the 1980s have also been a 'lost decade' for millions of children in some of the world's most affluent societies. Over the last 10 years, the proportion of children living below their nations' official poverty lines has increased in most of the nations of the West - including Canada, Germany, Ireland, the United Kingdom and the United States.

Fig.8 Child malnutrition in the developing world, 1990

The pie chart at the top shows the *absolute numbers* of malnourished children in the world, broken down by regions. The bar chart at the bottom shows the *percentage* of children who are malnourished in each of those regions.

For the first time, figures from China are included in this global overview of malnutrition.





Malnourished is defined as more than two standard deviations below the desirable weight for age, and child malnutrition refers to the child population under the age of five.

Source: Based on "A Global, Regional and Country Assessment of Child Malnutrition", Beverley A. Carlson and Tessa M. Wardlaw, UNICEF Staff working Paper No. 7, New York, 1990; using 1990 population estimates and including China.

Water and sanitation: a measure of development

Year 2000 goal: Safe water and sanitation for all families.

The poorest fifth of humanity still lacks clean water and safe sanitation. The consequences - for health, for productivity, for the quality of family, social and economic life - sap every other aspect of human development. In particular, progress of all kinds is held back by the diversion of so much of the time and effort of women and girls to the task of providing water.

Access to safe water and hygienic sanitation is therefore an aim, a means and a measure of development. And increasing access to these two vital amenities will be as good a guide as any to real human progress in the last decade of the twentieth century.

Extraordinary efforts have put some countries, notably Bangladesh, India and Nigeria, on course to achieve universal access to clean water in the mid-to-late 1990s. But most countries will not, on present trends, reach the year 2000 goal of clean water for all, and hardly any will come close to the goal of safe sanitation. To give some idea of the overall magnitude of the task, the rate of expansion in water supply achieved during the 1980s would have to be approximately doubled during the 1990s if the goal is to be reached.

In view of these daunting requirements, what is there to suggest that the year 2000 goal is anything other than unrealistic?

The first platform for a rapid advance in the 1990s is technological innovation and the consequent lowering of per capita costs. The cost of sinking a borehole and installing a hand pump system in Nigeria, for example, has fallen from over $15,000 in 1980 to $4,000 today.

Many different technologies which are acceptable, understandable, affordable and sustainable have been evolved and the overall costs of water and sanitation have fallen to an average initial capital investment of $30 per person plus maintenance costs which are often as low as $1 per person per year.

The second basis for hope is the possibility of releasing more resources by a relatively small change in the balance of existing spending. In the 1980s, only 20% of the $10 billion being invested in water and sanitation has been used for low-cost (less than $30 per head) schemes for the majority. The other 80 per cent is being allocated to schemes costing $550 per person or more. If this 4 to 1 ratio were to change to 3:1 by 1995 and 2:1 by the year 2000, then it would be possible to accelerate coverage very rapidly towards the year 2000 goal.

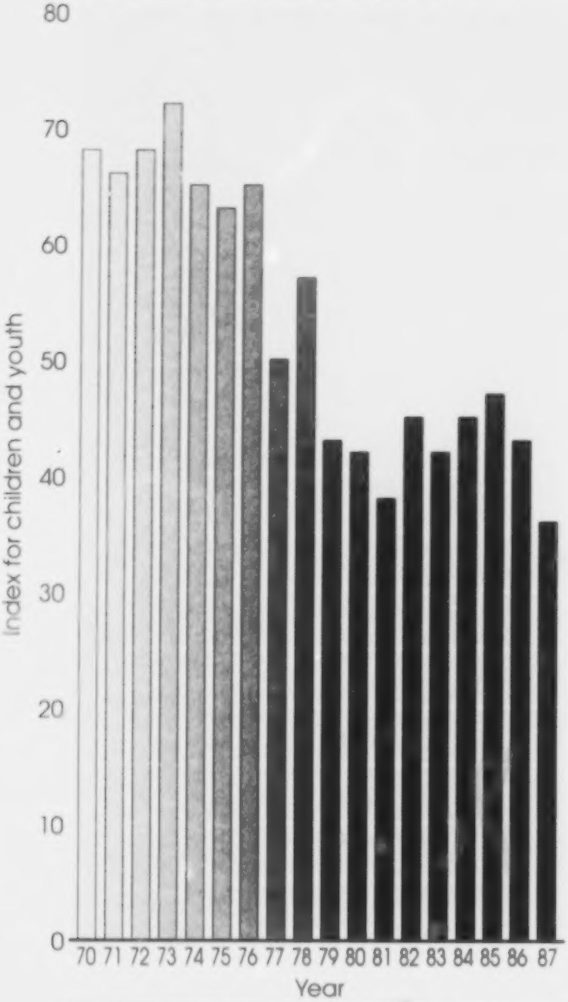
A third opportunity is the possibility of investing more resources in water and sanitation through user charges. There will be many circumstances in which charges for water mean that the poorest are deprived. But there are many millions of poor communities in which people are now paying more to buy water of dubious quality from private vending trucks and carts than would be required to finance a clean piped water supply.

A fourth advantage for the next decade is the experience which has been gained from the last. In particular, it is widely accepted that the ratio of resources to results can be multiplied by learning from the three most common failures of the past - failure to involve communities, failure to match technological intervention with health education and failure to respectfully involve the women who are the managers of water throughout the developing world.

Finally, experience also suggests that five-yearly monitoring of progress is not enough: Annual reviews, at the highest political level, are probably essential to success.

Fig.9 Social health of children and youth, USA, 1970-87

The graph shows changes in the *Index of Social Health for Children and Youth* in the United States. The index is a composite measure, on a 0 to 100 scale, of performance in six critical areas: infant mortality, child abuse, child poverty, teenage suicide, drug abuse, and high-school drop outs.



Source: "Measuring the Social Well-Being of the Nation", Fordham Institute for Innovation in Social Policy, Fordham University Graduate Center, NewYork, 1989.

In the United Kingdom, for example, the proportion of children living in families where income is below half the average income for the nation has more than doubled in a decade - from 12% in 1979 to 26% in 1989. In New York City, 40% of children now live below the official poverty line.

The United States probably does more to publicize such statistics than many industrialized nations (fig. 9), but as a recent essay by Harvard paediatrician Berry Brazelton has pointed out, "*the figures are widely reported, but too rarely followed up by action. Tax-payers and legislators are not yet determined to ensure that every child has the opportunity to grow up healthy and whole, to be secure, and to become literate and economically productive*".

Every argument made in this report for the emergence of a new ethic for children is also applicable to the industrialized countries. Most of the analyses brought together in the October 1990 *Time* magazine story on the plight of America's children, for example, are strikingly similar to the arguments made in this report for a first call for children in the context of the developing world:

"Kids' brains can't wait for Dad to get a new job or for Congress to come back from recess ... Why can't public-policy makers see the connection between bad infant nutrition, which is cheap and easy to fix, and developmental problems, which are expensive and often difficult to fix?"

Dr. Deborah Frank, Director of Growth and Development, Boston City Hospital

"Children who go unheeded are children who are going to turn on the world that neglected them."

Harvard psychiatrist Robert Coles

"If compassion were not enough to encourage our attention to the plight of our children, self-interest should be."

New York State Governor Mario Cuomo

"The inattention to children by our society poses a greater threat to our safety, harmony and productivity than any external enemy."

Marian Wright Edelman,
President, Children's Defense Fund

Facts for Life: health knowledge for all

In March 1990, 100 medical experts, including 20 Ministers of Health, met to discuss child health priorities for the decade ahead. Among the seven points in the 'Affirmation of Bangkok' was *"high priority to the dissemination of the information contained in* Facts for Life".

The *Facts for Life* initiative is based on a booklet which brings together, in non-technical language, today's essential child health knowledge. Issued by UNICEF, WHO, UNESCO and over 100 non-governmental organizations, the booklet contains information that all parents can act on and that could save the lives and protect the health of many millions of children. Its messages are organized under ten chapter headings: Timing births, Safe motherhood, Breast-feeding, Weaning, Immunization, Diarrhoeal disease, Respiratory infections, Domestic hygiene, Malaria and AIDS.

So far, more than two million copies of *Facts for Life*, including many national versions, have been published in 80 languages. But the booklet itself cannot reach more than a small fraction of the intended audience. Much more important is the mobilization of all communication channels - including the worlds of religion, education, mass media, commerce, voluntary movements, health services - to put its messages at the disposal of all.

The 'top ten' from the 55 messages in *Facts for Life*:

○ The health of both women and children can be significantly improved by spacing births at least two years apart, by avoiding pregnancies before the age of 18 and by limiting births to four.

○ All pregnant women should go to a health worker for pre-natal care, and all births should be assisted by a trained person.

○ For the first few months of a baby's life, breast milk alone is the best possible food and drink. Infants need additional foods when they are four to six months old.

○ Children under three need to eat five or six times a day. Their food should be specially enriched by adding mashed vegetables and small amounts of fats or oils.

○ Diarrhoea can kill by draining too much liquid from a child's body. So the liquid lost must be replaced by giving the child plenty of the right liquids to drink - breast milk, diluted gruel, soup or a special drink called ORS. If the illness is more serious than usual, the child needs help from a health worker - and the special ORS drink. A child with diarrhoea also needs food to make a good recovery.

○ Immunization protects against diseases which can cause poor growth, disability and death. All immunizations should be completed in the first year of the child's life. Every woman of child-bearing age should be immunized against tetanus.

○ If a child with a cough is breathing much more rapidly than is normal, then the child is seriously ill and it is essential to go to a health centre quickly. A child with a cough or cold should be helped to eat and to drink plenty of liquids.

○ Many illnesses are caused because germs enter the mouth. This can be prevented by using latrines; by washing hands with soap and water after using the latrine and before handling food; by keeping food and water clean; and by boiling drinking water if it is not from a safe piped supply.

○ Illnesses hold back a child's growth. After an illness, a child needs an extra meal every day for a week to make up the growth lost.

○ Children should be weighed every month from birth to the age of three years. If there is no gain in weight for two months, something is wrong.

Nor are the problems exclusively economic. Reported cases of child abuse in New York City have quadrupled from 600,000 to 2.4 million in the last 10 years. In some industrialized nations, one child in three suffers the breakdown of the family. In others, one child in six is under treatment for some kind of psychiatric disorder. And unknown millions of children are living with loveless affluence, with demoralization, with violence, and with drugs.

A new ethic for children is therefore as relevant to the industrialized nations as it is to the developing world, and unless this principle is found or refound, the new cold war will not be between nations but between the affluent and the alienated of our own societies.

The children of Eastern and Central Europe

The lesson which must be learned from the pain of adjustment to debt and recession in the developing world in the 1980s is that unless we have *specific* policies to protect children then it is undoubtedly they who will suffer the most. In other words it is especially in periods of transition and turbulence that the principle of first call for children is most necessary.

This principle is therefore of obvious relevance to the USSR and the countries of Central and Eastern Europe at this time. Too little data is available to form an overall picture. But it is clear that turbulence will continue to be generated by the political and economic changes of the years immediately ahead. The consequences of the arrangements made between the International Monetary Fund and several nations of Eastern Europe are not essentially different from those experienced by many developing nations in recent years - including cuts in government budgets, devaluation, price increases and the abolition of consumer subsidies. Experience therefore suggests that it is essential to put in place the systems which can sensitively monitor the effect of such measures on the health, nutrition and education of the children of Eastern Europe.

Without specific action for children, the likely results are well known. Following price liberalization, there is already evidence from both Poland and Hungary of significant declines in milk and meat consumption during the last year (1990). The cost of essential items such as drugs and school textbooks has also risen so steeply that Poland's Ministry of Education now estimates that the cost of equipping a child with the necessary books and materials for the first year of primary school has surpassed 50% of the average monthly salary. Similarly, the cost of meals for a child in kindergarten can claim 20% of a parent's monthly income. Without detailed monitoring, it is impossible to know what is happening to the children of Eastern Europe in these times. But the warning signs are surely there.

A further worry is the rapid deterioration of the environment, especially in the mining and heavy industry areas of Poland, the Czech and Slovak Federal Republic, the former territories of the German Democratic Republic and the USSR. Already, there are signs of increasing childhood asthma, respiratory infections, eye problems, food allergies, and even intolerance to maternal milk among newborns. Most tragic of all are the sufferings of the children of Chernobyl.

As individual nations, and the international community, begin to address these newly surfacing problems, it is essential to remember that it is children who are most vulnerable to environmental deterioration and that it is children who need a first call on our capacity to prevent and protect.

The Convention

In these different ways, the principle of first call is of pointed relevance to all regions of the world in the 1990s.

The universal expression of that principle is the Convention on the Rights of the Child which was adopted by the General Assembly of the United Nations on November 20th 1989. Since then, the Convention, of which the full

AIDS and children: coping with a calamity

AIDS will have a severe impact on both adult and child death rates, especially in sub-Saharan Africa, during the 1990s. The virus casts a dark shadow over prospects for major gains in child survival and development.

Babies born to women infected with HIV, the virus which causes AIDS, have a 20-40% chance of contracting the virus from their mothers. Almost all of these children will die before the age of five. By the end of the 1980s, according to the World Health Organization (WHO), an estimated 3 million women world-wide, including 2.5 million in sub-Saharan Africa, were infected with HIV, and an estimated 500,000 babies had contracted the virus from their mothers. By 1992 the total number of infants born with HIV infection, in Africa alone, is expected to reach 1 million, of whom 600,000 are likely to have developed AIDS and many will already have died.

Millions of children who are *not* infected with HIV are already suffering emotional and economic deprivation because their parents have died or are chronically ill. WHO estimates that during the 1990s more than 10 million children uninfected with HIV will be orphaned by AIDS. In many parts of sub-Saharan Africa, the extended family system, which has traditionally absorbed orphans, will come under severe strain as parents die of AIDS, leaving aged grandparents to cope with large numbers of young children.

An international effort continues to be urgently needed in order to:

○ Prevent HIV infection. The key strategy here is AIDS education through all possible channels - religious and community organizations, women's groups, the mass media, the health services, schools and colleges, artists and entertainers. Women must also be given more say in decisions about their own health and sexual behaviour, especially by improving their incomes and education.

○ Provide health care and social and economic support for families in which a child or a parent has HIV/AIDS and to families and communities caring for children orphaned by AIDS. The guardians of these children must be helped to provide them with a basic level of food, shelter, health care and education. Without such support, AIDS orphans will be condemned to poverty. Many will die prematurely; others will resort to crime and prostitution and will themselves be at high risk from AIDS.

Although AIDS cannot be cured, many of its symptoms can be treated with low-cost, basic drugs. Sensitive counselling can help people with HIV/AIDS to live longer and enhance their quality of life through 'living positively'. In countries such as Ghana, Uganda and Zambia, non-governmental organizations now provide 'home-based care' programmes, which are also an entry point for educating the wider community.

The AIDS pandemic comes at a time when many developing nations are having to freeze or even reduce their expenditure on primary health care and social services. In most sub-Saharan African countries, the health services lack the essential drugs, supplies and transport needed to provide minimum care to people with HIV/AIDS. Increased international assistance to meet these needs is urgently required. Health workers also need special training, particularly in counselling skills and in the diagnosis and treatment of infants and young children with HIV/AIDS, who may be slow to respond to standard treatments for common illnesses.

The eventual scale and impact of the AIDS disaster depends on how quickly policy makers, professionals and the general public become aware of the full scale of the threat and begin taking the obvious steps to contain it.

See also: Children and AIDS: An impending calamity, UNICEF 1990.

text is published alongside this 1991 *State of the World's Children* report, has been signed by over 130 nations and ratified by approximately 60 - by far the most rapid ratification of any international Convention in history.

This too is a part of the promise that has been made to the children of the 1990s.

The Convention speaks to three basic rights of the child. It speaks of the right to survival, a right which is at present denied to 14 million children each year, and calls for a rapid deployment of today's means of preventing most of those deaths (panel 2). It speaks also of the right to development, a right which is at present denied to those who are malnourished, to those who live with frequent illness, to those who have no opportunity to be educated, and to those who do not have the freedom to receive and to express information and ideas. It speaks, lastly, of the right to protection, a right which is now denied to millions of children, in both industrialized and developing worlds, who are used in wars, who are exploited at work, who are physically and sexually abused in their own homes, who are abandoned on the streets, who suffer mental cruelty, or who are victims of violence and drug abuse (panel 16).

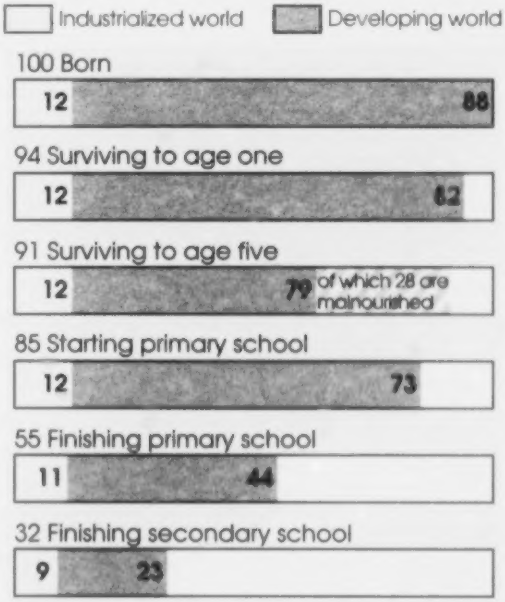
Some progress has already been made towards the protection of children caught up in the traumas of armed conflict. For three days of every year since 1985, fighting in El Salvador's civil war has been stopped to allow all children to be immunized - in recognition of the principle that the child's one chance for normal healthy growth should not be sacrificed even in the extreme case of civil or international war. Similarly, 'corridors of peace' have been established in the Sudan so that essential supplies can reach civilian families and their children. This policy - that children should be a 'zone of peace' in any conflict - has since been recommended to all member states by the Organization of African Unity and negotiations are well advanced for its application in Angola and in Ethiopia.

Encouraged by these small but important beginnings, the World Summit for Children advanced the principle still further by writing into its final Declaration the statement that "*The essential needs of children and families must be protected even in times of war and in violence-ridden areas. We ask that periods of tranquillity and special relief corridors be observed for the benefit of children, where war and violence are still taking place.*"

The world-wide observance of the Convention on the Rights of the Child is also one of the major goals adopted by the World Summit for Children. To realize this goal, the early part of the 1990s will have to see the increasing involvement of politicians, press, and public in

Fig.10 The children of the 1990s

142 million children have been born into the world during 1990. The chart below presents this huge number as just 100 children and gives a schematic overview of what will happen to them in the decade ahead.



Source: UNICEF estimates based on United Nations projections

Guinea worm disease: elimination by 2000

Year 2000 goal: Complete elimination of the disease.

Every year, guinea worm disease brings months of crippling pain to millions of people in 19 African countries and in parts of India and Pakistan. Men and women cannot work in the fields. Harvests are lost. Children cannot attend school. Earning and learning are undermined, and with them the foundations of community development. Highly localized, the disease torments many of the world's poorest and last-to-be-reached villages.

There is no medical treatment. But the disease can be prevented relatively easily and inexpensively. Complete elimination is possible in the 1990s.

Guinea worm disease *(dracunculiasis)* is caused by humans walking into the same water they use for drinking. Shallow pools and step wells contain the microscopic cyclops which carry the guinea worm larvae. Once taken into the human body, the female guinea worm grows into a metre-long white thread which can yield up to 3 million larvae. About a year afterwards, the white worm begins to find its way out of the human body through a burning blister, usually in the lower leg. When the victims steps into water, the larvae are dispersed. If the same water is used for drinking, the cycle begins all over again. No immunity is developed and repeat infections are common.

One solution is safe water supply - by means of stand-pipes, protected wells, or boreholes and handpumps. Although this is clearly the preferred solution, experience has shown that investments in safe water supply will not yield the expected health dividends unless the community is fully involved and informed on matters of maintenance and hygiene.

With safe water and health education, the disease can be eliminated from a community within a few years. The number of reported cases in India, for example, has been reduced from almost 45,000 in 1983 to only 12,000 in 1988. Similarly, absenteeism in Nigerian schools was reduced from 30% to 3% within three years by the installation of covered wells and handpumps. In some areas, where over 10% of working days and even larger proportions of the harvest are regularly lost to guinea worm disease, the economic benefits of elimination would far outweigh the cost of the investment even before taking into acount the reduction in women's work-loads and in the frequency of childhood diseases such as diarrhoea.

There are also less expensive interim solutions for communities without piped water supply. Boiling of drinking water or the chemical treatment of water sources with chlorination, iodination or a safe chemical larvicide will kill the larvae and prevent infection.

Even where chemical treatment is unavailable and the boiling of drinking water is impractical, communities can still protect themselves. By using fine cloths or nylon gauze, the microscopic cyclops can be filtered from drinking water. Villagers in Burkina Faso, where half of the population used to be infected with guinea worm, have now virtually eliminated the disease by this method.

Guinea worm affects some of the poorest people in some of the poorest countries. Although little heard of in the rest of the world, its costs, in health, in education, in productivity, in human suffering, are enormous. The Atlanta-based Carter Center, which monitors progress against guinea worm and has assisted many developing countries to attack the disease, now believes that victory is in view. Of the 21 affected nations, 16 have targeted the disease for elimination by the year 2000.

measuring their own societies against the provisions of the Convention. Adherence to, or breach of, the Convention on the Rights of the Child should rapidly become a matter of national concern, of national pride or of national shame.

The population question

The potential to reduce under-five deaths by at least one third in the next 10 years raises a question, in many minds, about the demographic consequences of such action. Would the saving of so many lives lead to even greater population pressures in the future?

In fact, the process of reducing child deaths is an essential part of the process of reducing birth rates.

Furthermore, the present potential for lowering death rates comes at a time when family planning programmes have been adopted and birth rates have begun to fall in almost every region of the developing world. Because of this, and because of the particular stage which most developing countries have now reached in the transition to lower birth rates, there is every reason to believe that further falls in under-five death rates would be associated with even steeper falls in births.

Finally, as this brief overview of the issue will show, the particular methods by which child deaths could now be reduced also happen to be among the most effective methods of reducing births.

For all of these reasons, the Plan of Action adopted by the heads of states and governments at the recent World Summit for Children expressly noted that *"the achievement of these goals would also contribute to lowering population growth"* *

Four forces

The pattern of forces which conspire to bring down birth rates, and the relative weights of the various factors involved, have been the subject of a great deal of research in recent years and are still not completely understood. But several consistent elements in that process have been broadly identified, of which four will be touched upon here:

1. Economic progress: Rising living standards, modernization, and urbanization, are usually accompanied by falling birth rates. A major reason is that economic progress tends to erode the advantages of large families (for example, help in fields and homes, and security in illness or old age) and to increase the cost of having children (for example, by adding to the expenditures necessary to house, feed, clothe and educate a child in accordance with the norms of a better-off society).

There are, however, several important examples, notably China, Sri Lanka and the Indian state of Kerala, where birth rates have been brought down to very low levels in the *absence* of significant growth in GNP per capita. In all of these examples, fertility has been reduced to almost industrialized world levels while per capita GNP remains at little more than $400 a year. The common feature in all of these cases is *social* progress - especially in education and health.

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* The goals themselves include *"Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many".*

2. *Improvements for women:* Of all the factors associated with falling birth rates, the one which is perhaps most closely and consistently correlated is improvement in the lives of women - in their status, in their emancipation and education, in their opportunities beyond childbearing, and in their acquiring not only the knowledge and the means but also the right to decide for themselves how many children they will have and when. In particular, the education of women seems to be one of the most consistently powerful factors in reducing birth rates.

3. *Family planning programmes:* Falling birth rates are also closely correlated with the availability of family planning education and services. In particular, the time-lag between falling death rates and falling birth rates can be abbreviated if the knowledge and the means of planning births are widely available to those families who wish to use them. Plotting the many different patterns by which countries have moved towards lower death rates and lower birth rates, it can be seen that those countries with strong family planning programmes have normally been able to translate progress in reducing deaths into progress in reducing births more quickly than those which do not.

4. *Reduced child deaths:* Another well-established element in catalyzing the transition to lower birth rates is the sustained reduction of child deaths. And it is striking that this is the factor common to all those countries, mentioned above, which have achieved very low birth rates while per capita incomes remain very low. Treating Kerala (population 29 million) as a country for the sake of the argument, it is worth pondering the statistic that China, Sri Lanka, and Kerala would all feature in the list of the 10 developing countries with the lowest fertility rates, the 20 developing countries with the lowest under-five mortality rates, and the 40 developing countries with the lowest per capita incomes. It is also worth remarking that if social progress had brought all of South Asia to the point at which under-five death rates and birth rates were at the levels prevailing today in Sri Lanka, then the region as a whole would see 5.2 million fewer child deaths each year - *and 14.3 million fewer births.*

Several mechanisms link lower child death rates to lower birth rates and, as this factor is the one which most commonly gives rise to concern about population growth, it is worth summarizing those mechanisms briefly here.

First, an infant death ends the suppression of ovulation which is caused by breast-feeding. In the absence of any other method of birth planning, a new pregnancy becomes more likely.

Second, the death of a child can also prompt couples to 'replace' the loss by a new pregnancy sooner than would otherwise have been the case.

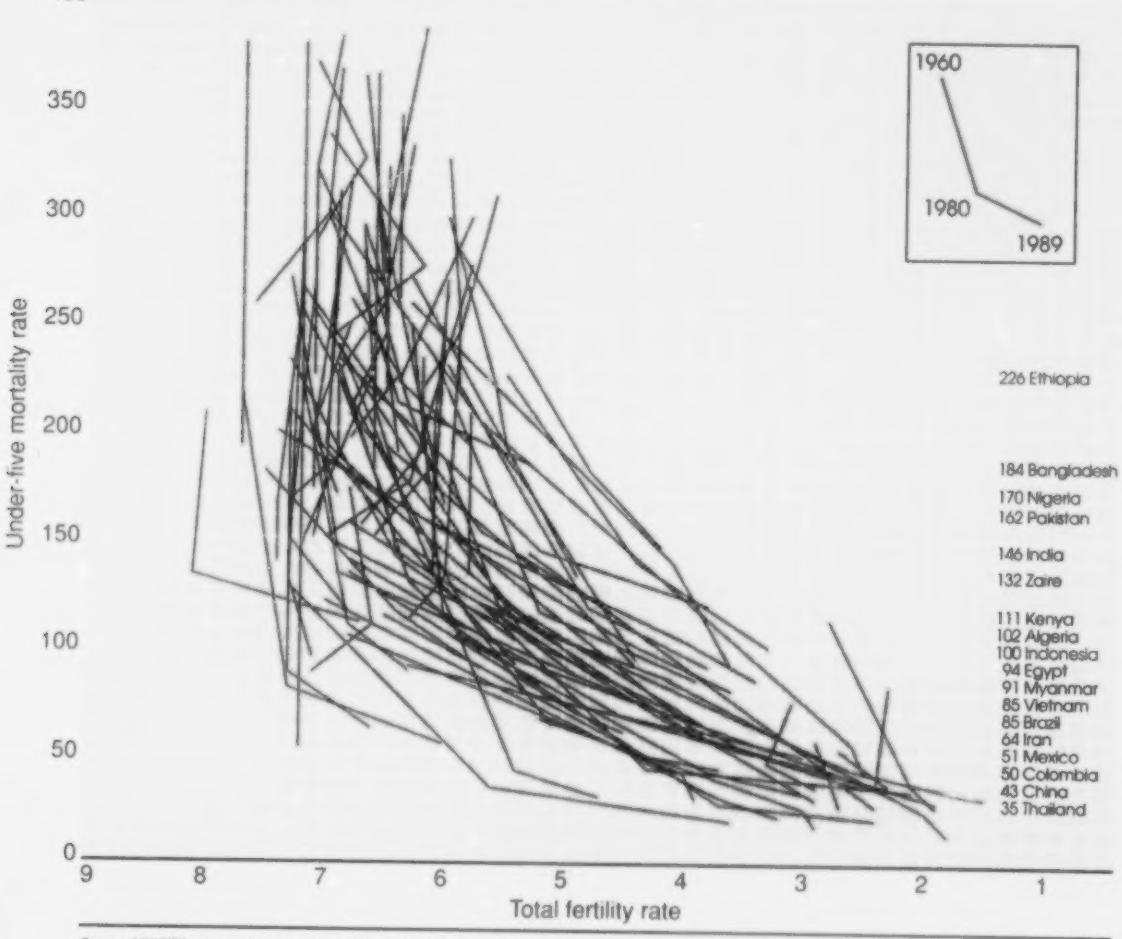
Third, when child death rates are high, many parents compensate for the anticipated loss of one or more of their children by giving birth to more children than they actually want or by not progressing to the stage of consciously planning the size of their families. Compounded by such factors as gender preference and the time-lag between changes in death rates and changes in *perceived* risks, this 'insurance effect' is a major reason for the persistence of high birth rates. Reducing child deaths can therefore help societies to move towards family building by design rather than by chance. This factor seems to become significant when child deaths become very unlikely from the parents' point of view. The process of family building then becomes more predictable, confidence begins to grow, and the 'insurance factor' begins to weaken. And it is this point in the process which many nations of the developing world are now approaching (fig. 11).

The confidence factor is an important one. When the relationship between the number of births and the number of surviving children is unpredictable and uncontrollable, then the idea of consciously planning a family of a specific size is not a proposition which can be easily accepted. Conversely, when child death rates fall and the relationship between the number of births and eventual family size becomes more predictable, planning becomes a more reason-

Fig.11 Under-five mortality rate (U5MR) and total fertility rate (TFR), 1960,1980 and 1989, all developing countries

Each line on the chart represents, for one developing country, the change in under-five mortality rate (U5MR) and total fertility rate (TFR) over the period from 1960 to 1989. The intermediate point on each line represents the point at 1980.

Almost all developing countries are represented on the chart. It shows that the initial steep falls in under-five death rates were often not accompanied by any significant change in fertility. Later, when under-five deaths fall still further, the pattern becomes mixed – with some countries showing significant falls in fertility and some not. In the later stages, further reduction of under-five deaths is – with very few exceptions – accompanied by even steeper falls in births. On the right hand side of the graph is shown the present under-five mortality rate of some of the most populous developing countries today. It can be seen that most are close to the level at which further falls in under-five deaths could be expected to be accompanied by even steeper falls in births.



Source: UNICEF, adapted from data supplied by the United Nations Population Division.

Vitamin A and iodine: eliminating disorders

Year 2000 goals: Virtual elimination of vitamin A deficiency and iodine deficiency disorders.

Lack of vitamin A in a child's diet causes a third of a million children to go blind each year. Sixty per cent of those children die within a short time of losing their sight. In addition, the deficiency exposes many millions of children to sharply increased risk of illness, poor growth and early death. Differences in mortality rates of up to 30% have been found between groups of children with and without vitamin A deficiency.

The body's need for vitamin A can be met by milk (especially breast milk), butter, eggs, liver and dark green or orange-coloured vegetables and fruits such as spinach, cassava leaves, carrots, yellow maize, red palm oil, papaya and mangoes. It is therefore essential that all parents know that such foods are essential for their children's health and eyesight.

The problem can also be solved by giving vitamin A capsules to all at-risk children every six months. The capsules cost 2 cents each and the cost of supplying the entire at-risk population of 150 million children would therefore be approximately $6 million per year. Several countries have now begun to distribute vitamin A capsules through immunization programmes.

Immunization itself also protects against deficiency by preventing measles - a major cause of vitamin A loss.

A third possible solution is the fortification of universally-used foods such as sugar with vitamin A.

The problem is concentrated in 37 countries of which only a minority have national control programmes.

Iodine deficiency

Although the human body requires only a teaspoonful of iodine in a whole lifetime, its lack is a major health risk for the one fifth of the world's population which lives in flood-prone or mountainous regions where iodine has been washed from the soil. The consequences include goitre (200 to 300 million people), mental retardation (approximately 20 million) and cretinism (at least 6 million). The deficiency can also cause miscarriages, still births and higher levels of infant mortality.

Children are most at risk. Without iodine, they can grow up stunted, mentally retarded, apathetic and incapable of normal movement, speech or hearing. Severe iodine deficiency at birth can mean cretinism. But even mild deficiencies can lead to poor performance at school and at work, locking communities into a cycle of poverty and ineducability.

The most effective remedy is to add iodine to common salt, which is consumed by everyone. This means co-operation between governments and salt industries, plus public education and careful monitoring. There are practical difficulties, but they are by no means insuperable. The main reason for not applying this relatively simple, low-cost solution is that the seriousness of the problem and the availability of an answer is not fully appreciated by those in a position to insist on the necessary action.

In the meantime, an immediate remedy is available in the form of iodized oil which can be given by injection (giving protection for about 5 years) or by mouth (2 years).

The costs of solving this problem are tiny in relation to the benefits. Iodization of salt costs approximately 5 cents per person per year (and can in most cases be met by a marginally higher salt price) and iodized oil costs approximately 10 cents per person per year. In total, the world-wide cost of applying known solutions to this major public health problem, including the costs of information and monitoring, would be in the region of $70 to $80 million per year.

able proposition. From the demographic record of many nations, the United Nations Population Division has concluded:

> *"Improvements in child survival, which increase the predictability of the family building process, trigger the transition from natural to controlled fertility behaviour. This in turn generates the need for family planning."*

Synergisms

In practice, these four broad factors in the transition to lower birth rates are synergistically related. Economic progress can assist women's advancement; women's advancement helps to reduce child deaths; reduced child deaths help to lower birth rates; lower birth rates help women's advancement. Or, to follow a different strand through this cat's cradle of synergisms, women's advancement (and especially secondary education) makes family planning more likely; family planning reduces both child deaths and child births; slower population growth can assist economic progress; economic progress can lead to lower birth rates, etc. etc.

The net result of thousands of such possible interconnections is that the whole is much greater than the sum of the parts; all of these forces acting together will exert a far greater downward pressure on birth rates than any one of them acting alone. Conversely, lack of progress in one area can inhibit progress in others: few countries, for example, have a rate of acceptance of family planning beyond 35% (of all couples of childbearing age) while under-five mortality rates remain much above 100 per 1,000 births; and it is uncommon to find under-five mortality rates below 100 if family planning acceptance remains much below 35%. The two are dynamically linked, and can progress most quickly if in step with each other. This is explicitly acknowledged by the Plan of Action adopted by the World Summit for Children which comments:

> *"There is an added benefit of promoting maternal and child health programmes and family planning together in that, acting synergistically, these activities help accelerate the reduction of both mortality and fertility rates, and contribute more to lowering rates of population growth than either type of activity alone."*

In the context of overall development, all of these basic factors in fertility decline - improvements in the lives of women, reduced child deaths, and the availability of family planning - are important priorities *in themselves*. All of them make a direct contribution to improving the lives of millions of people; the fact that they *also* make a strong synergistic contribution to solving the population problem, and that they can all be accomplished at a relatively modest cost, adds up to what should be an irresistible case for simultaneous action on all of these fronts in the decade ahead.

A particular compatibility

In addition to this general compatibility, the present potential for reducing child deaths is especially compatible with the need to reduce birth rates for two reasons, one of which has to do with the particular methods by which it might be achieved and the other with the particular time at which it arises.

Three of the most important strategies now available for reducing child deaths - the education of women, the well-informed timing of births, and breast-feeding - also happen to be among the most direct of all methods for reducing child births.

First, the education of mothers, by formal or informal means, is one of the most crucial determinants of children's health and survival (panel 10). Even when differences in income and residence are allowed for, the survival chances of a child born to a woman with four or more years of primary education are significantly greater than those of a child whose mother has never been to school. The reason for the strength of this tie between maternal education and child survival is not difficult to understand: an educated mother is more likely to be aware of the choices before her, more likely to be confident enough to seek help when

Protecting children: at war, at work, on the streets

Year 2000 goal: Observance of the Convention on the Rights of the Child, and protection for children in especially difficult circumstances.

In November 1989, the UN General Assembly adopted the Convention on the Rights of the Child (the full text of the Convention is published as an annexe to this report).

In addition to setting standards for children's survival, health and education, the Convention seeks to protect the millions of children who are exploited, abandoned or abused, wherever they may be. It is as concerned about the 2 million reported cases of child abuse in the United States each year (up threefold in ten years) as it is about the steep rise in Latin America's street children.

Of special concern are the children who are caught up in wars.

Children at war

Before 1945, most victims of war were soldiers. In the 150 wars since then, 80% of the 20 million dead and 60 million wounded have been civilians, most of them women and children.

Unknown numbers of children have been killed, wounded, abandoned, orphaned or taken as hostages. Millions will never see their families again. And an estimated 7 million children, mostly in Africa, are now growing up in refugee camps, often deprived of identity and nationality as well as adequate food, health care and education. Perhaps as many again are refugees in all but name, displaced from their homes without crossing a national boundary. Many of these children will find it impossible to grow up normally, to acquire skills and to find a job and a place in society.

Even larger numbers are indirect victims of war, their development disrupted by the closing of schools and clinics and the destruction of crops and roads.

Children are also being used to fight wars. In recent years, an estimated 200,000 under-fifteens have been recruited into armed forces, made to kill and to die and even to open the way across minefields at the cost of their lives and limbs.

The Convention seeks to outlaw the use of children in war and to promote the idea of children as a 'zone of peace' in order to protect the child's one chance to grow normally in mind and body. A beginning has been made. 'Corridors of peace' allowed essential supplies to reach the civilian victims of war in the Sudan. And in El Salvador, 'days of tranquillity' have interrupted civil war on 15 separate occasions so that children could be immunized.

Children at work ... and on the streets

An estimated 80 million children between the ages of 10 and 14 undertake work which is either so long or so onerous that it interferes with their normal development. Some are exploited in factories and sweatshops, but the majority work in agriculture or in domestic service. Many children are born or sold into the virtual slavery of bonded labour.

Overlapping this problem, an estimated 30 million children live on city streets, children who have run away or been abandoned or orphaned. Most of those children are deprived of health care and education and almost all are faced with the difficult choice of either resisting or falling in with the violence, crime, prostitution and drug abuse which are facts of street life from Lima and Rio to Bombay, Lagos and New York.

What can the Convention - a piece of paper - do against this cruel weight of real-world problems? Like other such documents in human history, it articulates a universally accepted ideal which, with sustained pressure from politicians, press and public, can eventually become the standard below which any nation, rich or poor, will be ashamed to fall.

needed, more likely to take more control over what happens to her family. By the same token, it is hardly surprising that female education is also associated with family planning and *fewer births*.

Second, the promotion of birth spacing is also one of the most important means by which reductions in child deaths could now be achieved (panel 8). A great many of those 40,000 children who die each day in the developing world are children born to mothers who are younger than 18, or older than 35, or who have had more than four children already, or who have given birth less than two years after a previous delivery. Infants born closer together than 24 months, for example, are approximately twice as likely to die in early childhood as babies born more than two years apart. Empowering families with that knowledge, and enabling them to act on it by providing culturally acceptable methods of family planning, is therefore one of the powerful levers for preventing both deaths *and births*.

Third, the promotion of breast-feeding is clearly a key element in child health and survival in the 1990s (panel 9) and, as has already been mentioned, on-demand breast-feeding is also an important if not wholly reliable method of preventing conception.

In addition to these direct links between particular means of reducing child deaths and the lowering of birth rates, it is noticeable that most of the other low-cost methods now available for protecting the lives of children fall into the category of those actions which increase parental involvement and parental control over child deaths. For this reason, they are the kind of strategies which are also likely to assist the spread of family planning. Taking a child to be immunized on several occasions in the first year of life, improving weaning methods, checking growth, administering oral rehydration therapy, recognizing the symptoms of acute respiratory infections - all depend on the well-informed and well-supported actions of *parents*. And as the UN Population Division has said:

"Those improvements in child survival that directly involve families are likely to give them a sense of control over their fate in a way that exogenous improvements cannot. Therefore, any given improvement in mortality will be more likely to initiate fertility control behaviour among those who understand and participate in that improvement than among those who do not."

The particular stage

The second factor which makes the year 2000 goals for improved child survival especially compatible with the aim of also reducing birth rates concerns the changed timing and context of the 1990s.

In contrast to the past, a majority of the developing countries are now at a stage when further falls in under-five death rates are likely to result in even steeper falls in birth rates.

The under-five mortality rate, or U5MR, is the number of deaths under the age of five per 1,000 live births. In the first phase of mortality decline, when U5MR first begins to fall from a very high level of 300 or more, birth rates tend to change very little. The great majority of countries in the developing world have now completed this phase. In the next stage, when countries begin to come below a U5MR of 200, there is no particular pattern of fertility change. Some countries have seen quite steep falls in fertility levels during this stage, others continue to see U5MR fall without any significant change in birth rates. In other words, the correlation between falling under-five mortality and falling fertility is very weak in comparison with other factors such as female education or a strong family planning programme. But it is when countries begin to bring the U5MR below 150, and to move towards and through the 100 mark, that very strong and consistent patterns of fertility change begin to emerge. And at this stage, almost all countries see a steeper fall in the number of births for every further fall in under-five mortality (fig 11).

The truly significant point raised by this closer look at the different stages of mortality decline, is that the great majority of developing countries have now passed through the earlier

Action for children: and the environment

A new deal for children in the 1990s would also make a major contribution to the cause of environmental protection.

First, reducing child death rates is a fundamental factor in slowing population growth (panel 7). No developing country has achieved a significant reduction in birth rates without also achieving a significant reduction in child deaths. One reason is that when parents become more confident that their children will survive, they no longer feel the need to over-insure against child deaths by having more children than they want. Many developing countries are now at the critical 'point of parental confidence' where further reductions in child deaths are likely to bring even greater reductions in births.

In addition, several of the most powerful strategies now available for reducing child deaths - such as the promotion of birth spacing and breastfeeding and the education of women - are also among the most powerful of all strategies for reducing overall fertility.

Second, a major environmental problem for a large proportion of mankind is inadequate or unsafe water supply which, together with unsafe sanitation, is responsible for perhaps three quarters of all infections and most child deaths in the developing world. This environmental problem is not threatening - it is happening. And action to protect children, including clean-water wells for household use and small-scale irrigation, the building of environmentally safe latrines, and health education, is also action for basic environmental improvement in communities throughout the world.

Third, the commitment to achieve basic education for every child by the end of the 1990s (panel 10) is also a fundamental prerequisite for environmentally sound development in the years to come. The choices which today's children will have to make in the 21st century - whether they be choices about family size or land use or energy source or waste disposal - can only be wisely made by a literate and informed public capable of absorbing new knowledge and responding to it. And that will be largely decided by the level of commitment which is made to education in the decade ahead.

Lastly, easing the debt crisis, increasing aid flows and reaccelerating economic progress in the developing world also unite both concern for children and concern for the environment. According to a special report on environment and sustainable development prepared by UNICEF in 1989:

"Many countries, especially in Africa and Latin America, have little possibility of pursuing the 'sustainable economic policies' recommended by the Brundtland Commission when they are forced to deplete their forests, soil, water, and other natural resources in order to pay their external debt, provide for essential imports and meet their unavoidable budgetary obligations".

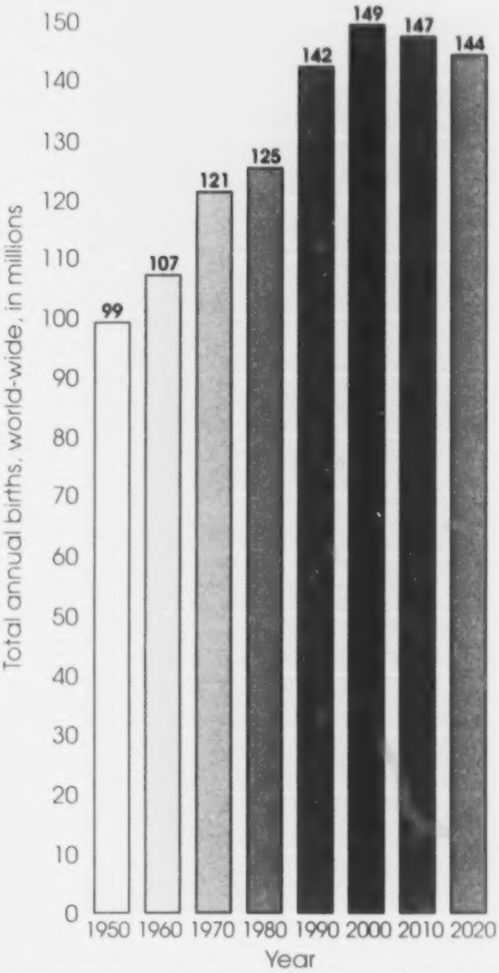
For the majority of mankind, the greatest environmental threat is not progress but poverty. Poverty and the lack of alternatives drive rural people to the burning of forests, the tilling of marginal lands, the over-dependence on finding grazing for cattle, the over-cutting of trees for fuel. Poverty and lack of confidence in the future are also engines of rapid population growth.

It is therefore rising prosperity which can do most to protect that environment. Smallholders who have security of tenure, who are literate, who have access to credit and scientific advice, who have markets for their crops and roads to get them there, who have small farm machines and a degree of security, instead of large families are the best safeguards for sustainable development.

If the safeguarding of the environment is to depend on the co-operation of the poor, then it must also offer families improvements in their lives today and a clear stake in a better life for themselves and their children tomorrow.

Fig.12 Total annual number of births, world-wide, 1950-2020

The total annual number of children being born into the world is predicted to reach a peak at about the year 2000, and to begin a slow decline as the 21st century begins.



Note: Estimates for 1950-80, and projections (medium variant) for 1990-2020

Source: UN Population Division, World Population Prospects 1988

stages of this transition, when fertility may or may not be affected, and are now entering the stage during which further falls in mortality rates could be expected to be associated with very steep falls in fertility rates. In other words, reductions in child deaths have now reached the point where the major dividends in falling birth rates are about to be paid.

Second, past reductions in child deaths have often happened in the absence of, and even hostility towards, family planning programmes. Where this has been the case, birth rates have usually been slow to respond to falling child deaths. Today, almost every developing country has an established, if not always adequately funded, family planning programme. For both of these overlapping reasons, further falls in under-five deaths could be expected to be accompanied by even more significant falls in births.

The population challenge of the next 10 years and beyond is therefore the challenge of 'cutting the corner' on the graph which plots falling mortality against falling fertility so that gains in the former are quickly translated into gains in the latter.

In addition to changes in the international economic climate which would enable the developing world to earn a higher standard of living, that challenge can best be met by a much greater national and international investment in culturally acceptable family planning programmes, in the empowering of parents with today's knowledge, in a significant expansion in educational opportunities - especially for women and girls - and in the achievement of the year 2000 goal of a significant reduction in under-five mortality rates.

Family planning

In conclusion, it should be clearly stated that family planning would still be one of the highest priorities, even if population growth were not a concern. As has been mentioned, and as is discussed in panel 8, the well-informed timing and spacing of births is one of the greatest of

The USA: year 2000 health goals

The usefulness of specific health goals for increasing political, professional and public commitment, is not confined to the developing world. The United States Government has also announced national health targets for the year 2000, including 19 goals relating specifically to the well-being of mothers and children.

As UNICEF and others have urged in the context of the developing world, the US health goals include the concepts of social mobilization and disparity reduction. Social mobilization implies enlisting all possible communications resources to inform and support people in using today's health knowledge. Disparity reduction means disaggregating national statistics and focusing action on any group, whether defined by race, sex, income or physical location, in which health problems are concentrated.

Many of the US goals include separate targets for black Americans, American Indians, Alaskan Natives and low-income groups. In the developing world, breaking down the statistics into male/female would reveal even more significant disparities. The idea of disparity reduction, applied to any social goal, helps to focus resources and achieve overall goals in the shortest time and at the lowest cost.

In the following examples of the US goals, comparable figures for the developing world are given where possible.

○ Reduce the infant mortality rate to no more than 7 per 1,000 live births (from a baseline of 10.4 in 1986). Among blacks, the target is 11 per 1,000 (18 in 1986). *The year 2000 target for the developing world is a one-third reduction of the 1990 rate or a reduction to 50 per 1,000, whichever is less.*

○ Halve the maternal mortality rate to no more than 3.6 per 100,000 live births (from 7.2 in 1986). Among blacks, the target is a near 75% reduction to 5 per 100,000 (from almost 19 in 1986). *The year 2000 target for the developing world is a halving of the 1990 maternal mortality rate which stands today at 640 per 100,000 in Africa, 572 in South Asia, 55 in East Asia and 270 in Latin America.*

○ Reduce to no more than 1 per 1,000 the prevalence of HIV infection among women giving birth to live-born infants (from approximately 1.4 per 1,000 in 1986).

○ Reduce low birth-weight (less than 2,500 grammes) to an incidence of no more than 5% of live births (from 6.8% in 1986). Among blacks the target is 9% (from 12.5% in 1986). *The target for the developing world is a reduction to 10% or less (from a 1984 incidence of approximately 20% in Asia and 14% in Africa).*

○ Increase to at least 75% the proportion of mothers who exclusively or partially breast-feed their babies in the early postpartum period and to at least 50% the proportion who continue breast-feeding until their babies are five to six months old, (from 54% and 21% respectively in 1988).

○ Increase abstinence in the use of tobacco, alcohol, cocaine and marijuana among pregnant women by at least 40%.

○ Increase to at least 90% the proportion of women ages 15 through 44 who know that alcohol, smoking and other drug abuse during pregnancy pose risks to the fetus.

○ Increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy (from 76% in 1986 - 62% among blacks, 61% among American Indians and Alaskan native women, 60% among Hispanic women).

all opportunities for improving the health and saving the lives of both women and children in the decade ahead.

For the women of the developing world, child spacing can mean a drastic reduction in illness and disability, in maternal deaths, estimated at 500,000 per year, and in the number of abortions, estimated at more than 100,000 *every day*. For the children of the developing world, the responsible planning of family size can mean better levels of health, nutrition, and education, and is one of the most powerful means of achieving many of the most basic human development goals adopted for the year 2000.

In large measure, the demand for family planning - with respect for religious, cultural and social traditions - already exists. An estimated 300 million couples in the developing world do not want any more children but are not using any effective means of avoiding another pregnancy. Overall, *World Fertility Survey* findings in the 15 most populous developing countries suggest that if women had the power to make their own decisions on the matter, then family size would fall by an average of almost two children and the rate of population increase would drop by up to 30%.

Making it possible for women to exercise that choice would therefore have a significant effect on the health and well-being of women themselves, on the healthy growth and survival of their children, and on the lowering of fertility rates. Few things could achieve as much for the health and well-being of the human race, and few things could do more to give people more control over their own lives - the essence of the development process itself.

When so much could be achieved by the meeting of an existing demand, and at such a relatively small cost, the time has surely come for a major renewal of the effort to ensure that all couples, and especially all women, have the information, the means, the support and the *right* to decide for themselves how many children they will have and when they will have them. It is now 15 years since 140 nations, meeting at the first World Population Conference, agreed that "*all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so*". It is time that this right was made into a reality for the sake of today's mothers and children and for the sake of sustainable human development in the twenty-first century and beyond.

Conclusion

Despite the crises which continue to occur in international affairs, the ending of the cold war offers the possibility of a new era for mankind. The price of preoccupation with war has been more than financial; it has been a price paid in the distortion of our science and technology, in the absorption of our management and political skills, in the waste of our energies and ingenuities, and in the distraction of our vision and our imagination. The dividends of peace may also, therefore, be paid to the human race in many currencies, and above all in the liberation of financial and human resources for a renewal of what Robert Heilbroner, in the 1960s, called 'the great ascent'. In our times, the vision of a world in which every man, woman and child has adequate food, clean water, decent housing, modern health care, and a basic education, could at last be realized.

The World Summit for Children has given the world an extraordinary opportunity to take a series of concerted actions which would amount to the first steps on that long journey. It is an opportunity to pursue a known mix of strategies which could prevent the deaths of millions of women and children, invest in the health and education of the rising generation, and at the same time make a major contribution to the slowing-down of population growth. That mix of strategies is now within the capacity of any developing nation to implement and of any industrialized country to support.

On the Sunday before the Summit, over a million candles were lit for its success by ordinary people around the world. Each of those candles represented the inextinguishable hope in the hearts of people everywhere that, amid all the problems and the dangers of the years ahead, the world can still be made a better place. That hope has now taken on a definite form and a clear strategy. The challenge has been defined. Meeting that challenge will, as the Summit's Plan of Action says, "*demand consistent and extraordinary effort on the part of all concerned*".

On present trends, the number of children being born into the world each year is predicted to peak in about the year 2000 and begin to fall. The children of the 1990s will therefore be the largest generation ever to be entrusted to mankind. And the present generation will rightly be judged by how it meets the challenge of protecting their lives, their growth, their education, and their rights.

To guide that effort in the decade ahead, widespread acceptance must be won for a new ethic for children; an ethic which demands that children should be the first to benefit from mankind's successes and the last to suffer from its failures; an ethic which recognizes that it is on how society protects and cares for its children that its civilization is measured, its humanity is tested, and its future is shaped.

World declaration on the survival, protection and development of children

World declaration on the survival, protection and development of children

The World Summit for Children was held at the United Nations, New York, on the 30th September 1990.

1. We have gathered at the World Summit for Children to undertake a joint commitment and to make an urgent universal appeal - to give every child a better future.

2. The children of the world are innocent, vulnerable and dependent. They are also curious, active and full of hope. Their time should be one of joy and peace, of playing, learning and growing. Their future should be shaped in harmony and co-operation. Their lives should mature, as they broaden their perspectives and gain new experiences.

3. But for many children, the reality of childhood is altogether different.

The challenge

4. Each day, countless children around the world are exposed to dangers that hamper their growth and development. They suffer immensely as casualties of war and violence; as victims of racial discrimination, apartheid, aggression, foreign occupation and annexation; as refugees and displaced children, forced to abandon their homes and their roots; as disabled; or as victims of neglect, cruelty and exploitation.

5. Each day, millions of children suffer from the scourges of poverty and economic crisis - from hunger and homelessness, from epidemics and illiteracy, from degradation of the environment. They suffer from the grave effects of the problems of external indebtedness and also from the lack of sustained and sustainable growth in many developing countries, particularly the least developed ones.

6. Each day, 40,000 children die from malnutrition and disease, including acquired immunodeficiency syndrome (AIDS), from the lack of clean water and inadequate sanitation and from the effects of the drug problem.

7. These are challenges that we, as political leaders, must meet.

The opportunity

8. Together, our nations have the means and the knowledge to protect the lives and to diminish enormously the suffering of children, to promote the full development of their human potential and to make them aware of their needs, rights and opportunities. The Convention on the Rights of the Child provides a new opportunity to make respect for children's rights and welfare truly universal.

9. Recent improvements in the international political climate can facilitate this task. Through international co-operation and solidarity it should now be possible to achieve concrete results in many fields - to revitalize economic growth and development, to protect the environment, to prevent the spread of fatal and crippling diseases and to achieve greater social and economic justice. The current moves towards disarmament also mean that significant resources could be released for purposes other than military ones. Improving the well-being of children must be a very high priority when these resources are reallocated.

The task

10. Enhancement of children's health and nutrition is a first duty, and also a task for which solutions are now within reach. The lives of tens of thousands of boys and girls can be saved every day, because the causes of their death are readily preventable. Child and infant mortality is unacceptably high in many parts of the world, but can be lowered dramatically with means that are already known and easily accessible.

11. Further attention, care and support should be accorded to disabled children, as well as to other children in very difficult circumstances.

12. Strengthening the role of women in general and ensuring their equal rights will be to the advantage of the world's children. Girls must be given equal treatment and opportunities from the very beginning.

13. At present, over 100 million children are without basic schooling, and two-thirds of them are girls. The provision of basic education and literacy for all are among the most important contributions that can be made to the development of the world's children.

14. Half a million mothers die each year from causes related to childbirth. Safe motherhood must be promoted in all possible ways. Emphasis must be placed on responsible planning of family size and on child spacing. The family, as a fundamental group and natural environment for the growth and well-being of children, should be given all necessary protection and assistance.

15. All children must be given the chance to find their identity and realize their worth in a safe and supportive environment, through families and other care-givers committed to their welfare. They must be prepared for responsible life in a free society. They should, from their early years, be encouraged to participate in the cultural life of their societies.

16. Economic conditions will continue to influence greatly the fate of children, especially in developing nations. For the sake of the future of all children, it is urgently necessary to ensure or reactivate sustained and sustainable economic growth and development in all countries and also to continue to give urgent attention to an early, broad and durable solution to the external debt problems facing developing debtor countries.

17. These tasks require a continued and concerted effort by all nations, through national action and international co-operation.

The commitment

18. The well-being of children requires political action at the highest level. We are determined to take that action.

19. We ourselves hereby make a solemn commitment to give high priority to the rights of children, to their survival and to their protection and development. This will also ensure the well-being of all societies.

20. We have agreed that we will act together, in international co-operation, as well as in our respective countries. We now commit ourselves to the following 10-point programme to protect the rights of children and to improve their lives:

> 1) We will work to promote earliest possible ratification and implementation of the Convention on the Rights of the Child. Programmes to encourage information about children's rights should be launched world-wide, taking into account the distinct cultural and social values in different countries.
>
> 2) We will work for a solid effort of national and international action to enhance children's health, to promote pre-natal care and to lower infant and child mortality in all countries and among all peoples. We will promote the provision of clean water in all communities for all their children, as well as universal access to sanitation.
>
> 3) We will work for optimal growth and development in childhood, through measures to eradicate hunger, malnutrition and famine, and thus to relieve millions of children of tragic sufferings in a world that has the means to feed all its citizens.
>
> 4) We will work to strengthen the role and status of women. We will promote responsible planning of family size, child spacing, breastfeeding and safe motherhood.
>
> 5) We will work for respect for the role of the family in providing for children and will support the efforts of parents, other care-givers and communities to nurture and care for children, from the earliest stages of childhood through adolescence. We also recognize the special needs of children who are separated from their families.

6) We will work for programmes that reduce illiteracy and provide educational opportunities for all children, irrespective of their background and gender; that prepare children for productive employment and lifelong learning opportunities, i.e. through vocational training; and that enable children to grow to adulthood within a supportive and nurturing cultural and social context.

7) We will work to ameliorate the plight of millions of children who live under especially difficult circumstances - as victims of apartheid and foreign occupation; orphans and street children and children of migrant workers; the displaced children and victims of natural and man-made disasters; the disabled and the abused, the socially disadvantaged and the exploited. Refugee children must be helped to find new roots in life. We will work for special protection of the working child and for the abolition of illegal child labour. We will do our best to ensure that children are not drawn into becoming victims of the scourge of illicit drugs.

8) We will work carefully to protect children from the scourge of war and to take measures to prevent further armed conflicts, in order to give children everywhere a peaceful and secure future. We will promote the values of peace, understanding and dialogue in the education of children. The essential needs of children and families must be protected even in times of war and in violence-ridden areas. We ask that periods of tranquillity and special relief corridors be observed for the benefit of children, where war and violence are still taking place.

9) We will work for common measures for the protection of the environment, at all levels, so that all children can enjoy a safer and healthier future.

10) We will work for a global attack on poverty, which would have immediate benefits for children's welfare. The vulnerability and special needs of the children of the developing countries, and in particular the least developed ones, deserve priority. But growth and development need promotion in all States, through national action and international co-operation. That calls for transfers of appropriate additional resources to developing countries as well as improved terms of trade, further trade liberalization and measures for debt relief. It also implies structural adjustments that promote world economic growth, particularly in developing countries, while ensuring the well-being of the most vulnerable sectors of the populations, in particular the children.

The next steps

21. The World Summit for Children has presented us with a challenge to take action. We have agreed to take up that challenge.

22. Among the partnerships we seek, we turn especially to children themselves. We appeal to them to participate in this effort.

23. We also seek the support of the United Nations system, as well as other international and regional organizations, in the universal effort to promote the well-being of children. We ask for greater involvement on the part of non-governmental organizations, in complementing national efforts and joint international action in this field.

24. We have decided to adopt and implement a Plan of Action, as a framework for more specific national and international undertakings. We appeal to all our colleagues to endorse that Plan. We are prepared to make available the resources to meet these commitments, as part of the priorities of our national plans.

25. We do this not only for the present generation, but for all generations to come. There can be no task nobler than giving every child a better future.

New York, 30 September 1990

Plan of action for implementing the world declaration on the survival, protection and development of children in the 1990s

PLAN OF ACTION FOR IMPLEMENTING THE *World declaration on the survival, protection and development of children* IN THE 1990s

I. Introduction

II. Specific actions for child survival, protection and development

The Convention on the Rights of the Child
Child health
Food and nutrition
Role of women, maternal health and family planning
Role of the family
Basic education and literacy
Children in especially difficult circumstances
Protection of children during armed conflicts
Children and the environment
Alleviation of poverty and revitalization of economic growth

III. Follow-up actions and monitoring

Action at the national level
Action at the international level

Appendix:

Goals for children and development in the 1990s

I. Introduction

1. This Plan of Action is intended as a guide for national Governments, international organizations, bilateral aid agencies, non-governmental organizations (NGOs) and all other sectors of society in formulating their own programmes of action for ensuring the implementation of the Declaration of the World Summit for Children.

2. The needs and problems of children vary from country to country, and indeed from community to community. Individual countries and groups of countries, as well as international, regional, national and local organizations, may use this Plan of Action to develop their own specific programmes in line with their needs, capacity and mandates. However, parents, elders and leaders at all levels throughout the world have certain common aspirations for the well-being of their children. This Plan of Action deals with these common aspirations, suggesting a set of goals and targets for children in the 1990s, strategies for reaching those goals and commitments for action and follow-up measures at various levels.

3. Progress for children should be a key goal of overall national development. It should also form an integral part of the broader international development strategy for the Fourth United Nations Development Decade. As today's children are the citizens of tomorrow's world, their survival, protection and development is the prerequisite for the future development of humanity. Empowerment of the younger generation with knowledge and resources to meet their basic human needs and to grow to their full potential should be a primary goal of national development. As their individual development and social contribution will shape the future of the world, investment in children's health, nutrition and education is the foundation for national development.

4. The aspirations of the international community for the well-being of children are best reflected in the Convention on the Rights of the Child unanimously adopted by the General Assembly of the United Nations in 1989. This Convention sets universal legal standards for the protection of children against neglect, abuse and exploitation, as well as guaranteeing to them their basic human rights, including survival, development and full participation in social, cultural, educational and other endeavours necessary for their individual growth and well-being. The Declaration of the World Summit calls on all Governments to promote earliest possible ratification and implementation of the Convention.

5. In the past two years, a set of goals for children and development in the 1990s has been formulated in several international forums attended by virtually all Governments, relevant United Nations agencies and major NGOs. In support of these goals and in line with the growing international consensus in favour of greater attention to the human dimension of development in the 1990s, this Plan of Action calls for concerted national action and international co-operation to strive for the achievement, in all

countries, of the following major goals for the survival, protection and development of children by the year 2000.

a) Reduction of 1990 under-5 child mortality rates by one third or to a level of 70 per 1,000 live births, whichever is the greater reduction;

b) Reduction of maternal mortality rates by half of 1990 levels;

c) Reduction of severe and moderate malnutrition among under-5 children by one half of 1990 levels;

d) Universal access to safe drinking water and to sanitary means of excreta disposal;

e) Universal access to basic education and completion of primary education by at least 80 per cent of primary school age children;

f) Reduction of the adult illiteracy rate to at least half its 1990 level (the appropriate age group to be determined in each country), with emphasis on female literacy;

g) Protection of children in especially difficult circumstances, particularly in situations of armed conflicts.

6. A list of more detailed sectoral goals and specific actions which would enable the attainment of the above major goals can be found in the appendix to this Plan of Action. These goals will first need to be adapted to the specific realities of each country in terms of phasing, priorities, standards and availability of resources. The strategies for the achievement of the goals may also vary from country to country. Some countries may wish to add other development goals that are uniquely important and relevant for their specific country situation. Such adaptation of the goals is of crucial importance to ensure their technical validity, logistical feasibility, financial affordability and to secure political commitment and broad public support for their achievement.

II. Specific actions for child survival, protection and development

7. Within the context of these overall goals, there are promising opportunities for eradicating or virtually eliminating age-old diseases that have afflicted tens of millions of children for centuries and for improving the quality of life of generations to come. Achievement of these goals would also contribute to lowering population growth, as sustained decline in child death rates towards the level at which parents become confident that their first children will survive is, with some time lag, followed by even greater reduction in child births. To seize these opportunities the Declaration of

the World Summit for Children calls for specific actions in the following areas:

The Convention on the Rights of the Child

8. The Convention on the Rights of the Child, unanimously adopted by the United Nations General Assembly, contains a comprehensive set of international legal norms for the protection and well-being of children. All Governments are urged to promote earliest possible ratification of the Convention, where it has not already been ratified. Every possible effort should be made in all countries to disseminate the Convention and, wherever it has already been ratified, to promote its implementation and monitoring.

Child health

9. Preventable childhood diseases - such as measles, polio, tetanus, tuberculosis, whooping cough and diphtheria, against which there are effective vaccines, and diarrhoeal diseases, pneumonia and other acute respiratory infections that can be prevented or effectively treated through relatively low-cost remedies - are currently responsible for the great majority of the world's 14million deaths of children under 5 years and disability of millions more every year. Effective action can and must be taken to combat these diseases by strengthening primary health care and basic health services in all countries.

10. Besides these readily preventable or treatable diseases and some others, such as malaria, which have proved more difficult to combat, children today are faced with the new spectre of the acquired immunodeficiency syndrome (AIDS) pandemic. In the most seriously affected countries HIV/AIDS threatens to offset the gains of child survival programmes. It is already a major drain on limited public health resources needed to support other priority health services. The consequences of HIV/AIDS go well beyond the suffering and death of the infected child and include risks and stigmas that affect parents and siblings and the tragedy of "AIDS orphans". There is an urgent need to ensure that programmes for the prevention and treatment of AIDS, including research on possible vaccines and cures that can be applicable in all countries and situations, and massive information and education campaigns, receive a high priority for both national action and international co-operation.

11. A major factor affecting the health of children as well as adults is the availability of clean water and safe sanitation. These are not only essential for human health and well-being, but also contribute greatly to the emancipation of women from the drudgery that has a pernicious impact on children, especially girls. Progress in child health is unlikely to be sustained if one third of the developing world's children remain without access to clean drinking water and half of them without adequate sanitary facilities.

12. Based on the experience of the past decade, including the many innovations in simple, low-cost techniques and technologies to provide clean water and safe sanitary facilities in rural areas and urban shanty towns, it is now desirable as well as feasible, through concerted national action and international co-operation, to aim at providing all the world's children with universal access to safe drinking water and sanitary means of excreta disposal by the year 2000. An important related benefit of universal access to water and sanitation combined with health education will be the control of many water-borne diseases, among them elimination of guinea-worm disease (dracunculiasis), which currently afflicts some 10 million children in parts of Africa and Asia.

Food and nutrition

13. Hunger and malnutrition in their different forms contribute to about half of the deaths of young children. More than 20 million children suffer from severe malnutrition, 150 million are underweight and 350 million women suffer from nutritional anaemia. Improved nutrition requires (a) adequate household food security, (b) healthy environment and control of infections and (c) adequate maternal and child care. With the right policies, appropriate institutional arrangements and political priority, the world is now in a position to feed all the world's children and to overcome the worst forms of malnutrition, i.e. drastically to reduce diseases that contribute to malnutrition, to halve protein-energy malnutrition, virtually to eliminate vitamin A deficiency and iodine deficiency disorders and to reduce nutritional anaemia significantly.

14. For the young child and the pregnant woman, provision of adequate food during pregnancy and lactation; promotion, protection and support of breastfeeding and complementary feeding practices, including frequent feeding; growth monitoring with appropriate follow-up actions; and nutritional surveillance are the most essential needs. As the child grows older, and for the adult population as a whole, an adequate diet is an obvious human priority. Meeting this need requires employment and income-generating opportunities, dissemination of knowledge and supporting services to increase food production and distribution. These are key actions within broader national strategies to combat hunger and malnutrition.

Role of women, maternal health and family planning

15. Women in their various roles play a critical part in the well-being of children. The enhancement of the status of women and their equal access to education, training, credit and other extension services constitute a valuable contribution to a nation's social and economic development. Efforts for the enhancement of women's status and their role in development must begin with the girl child. Equal opportunity should be provided for the girl child to benefit from the health, nutrition, education and other basic services to enable her to grow to her full potential.

16. Maternal health, nutrition and education are important for the survival and well-being of women in their own right and are key determinants of

the health and well-being of the child in early infancy. The causes of the high rates of infant mortality, especially neonatal mortality, are linked to untimely pregnancies, low birth weight and pre-term births, unsafe delivery, neonatal tetanus, high fertility rates, etc. These are also major risk factors for maternal mortality claiming the lives of 500,000 young women each year and resulting in ill-health and suffering for many millions more. To redress this tragedy, special attention should be given to health, nutrition and education of women.

17. All couples should have access to information on the importance of responsible planning of family size and the many advantages of child spacing to avoid pregnancies that are too early, too late, too many or too frequent. Pre-natal care, clean delivery, access to referral facilities in complicated cases, tetanus toxoid vaccination and prevention of anaemia and other nutritional deficiencies during pregnancy are other important interventions to ensure safe motherhood and a healthy start in life for the newborn. There is an added benefit of promoting maternal and child health programmes and family planning together in that, acting synergistically, these activities help accelerate the reduction of both mortality and fertility rates, and contribute more to lowering rates of population growth than either type of activity alone.

Role of the family

18. The family has the primary responsibility for the nurturing and protection of children from infancy to adolescence. Introduction of children to the culture, values and norms of their society begins in the family. For the full and harmonious development of their personality, children should grow up in a family environment, in an atmosphere of happiness, love and understanding. Accordingly, all institutions of society should respect and support the efforts of parents and other care-givers to nurture and care for children in a family environment.

19. Every effort should be made to prevent the separation of children from their families. Whenever children are separated from their family owing to force majeur or in their own best interest, arrangements should be made for appropriate alternative family care or institutional placement, due regard being paid to the desirability of continuity in a child's upbringing in his or her own cultural milieu. Extended families, relatives and community institutions should be given support to help to meet the special needs of orphaned, displaced and abandoned children. Efforts must be made to ensure that no child is treated as an outcast from society.

Basic education and literacy

20. The international community, including virtually all the Governments of the world, have undertaken a commitment at the World Conference on Education for All at Jomtien, Thailand, to increase significantly educational opportunity for over 100 million children and nearly 1 billion adults, two thirds of them girls and women, who at present have no access to basic education and literacy. In fulfilment of that commitment, specific measures

must be adopted for (a) the expansion of early childhood development activities, (b) universal access to basic education, including completion of primary education or equivalent learning achievement by at least 80 per cent of the relevant school-age children with emphasis on reducing the current disparities between boys and girls, (c) the reduction of adult illiteracy by half, with emphasis on female literacy, (d) vocational training and preparation for employment and (e) increased acquisition of knowledge, skills and values through all educational channels, including modern and traditional communication media, to improve the quality of life of children and families.

21. Besides its intrinsic value for human development and improving the quality of life, progress in education and literacy can contribute significantly to improvement in maternal and child health, in protection of the environment and in sustainable development. As such, investment in basic education must be accorded a high priority in national action as well as international co-operation.

Children in especially difficult circumstances

22. Millions of children around the world live under especially difficult circumstances - as orphans and street children, as refugees or displaced persons, as victims of war and natural and man-made disasters, including such perils as exposure to radiation and dangerous chemicals, as children of migrant workers and other socially disadvantaged groups, as child workers or youth trapped in the bondage of prostitution, sexual abuse and other forms of exploitation, as disabled children and juvenile delinquents and as victims of apartheid and foreign occupation. Such children deserve special attention, protection and assistance from their families and communities and as part of national efforts and international co-operation.

23. More than 100 million children are engaged in employment, often heavy and hazardous and in contravention of international conventions which provide for their protection from economic exploitation and from performing work that interferes with their education and is harmful to their health and full development. With this in mind, all States should work to end such child-labour practices and see how the conditions and circumstances of children in legitimate employment can be protected to provide adequate opportunity for their healthy upbringing and development.

24. Drug abuse has emerged as a global menace to very large numbers of young people and, increasingly, children - including permanent damage incurred in the pre-natal stages of life. Concerted action is needed by Governments and intergovernmental agencies to combat illicit production, supply, demand, trafficking and distribution of narcotic drugs and psychotropic substances to counter this tragedy. Equally important is community action and education, which are vitally needed to curb both the supply of and the demand for illicit drugs. Tobacco and alcohol abuse are also problems requiring action, especially preventive measures and education among young people.

Protection of children during armed conflicts

25. Children need special protection in situations of armed conflict. Recent examples in which countries and opposing factions have agreed to suspend hostilities and adopt special measures such as "corridors of peace" to allow relief supplies to reach women and children and "days of tranquillity" to vaccinate and to provide other health services for children and their families in areas of conflict need to be applied in all such situations. Resolution of a conflict need not be a prerequisite for measures explicitly to protect children and their families to ensure their continuing access to food, medical care and basic services, to deal with trauma resulting from violence and to exempt them from other direct consequences of violence and hostilities. To build the foundation for a peaceful world where violence and war will cease to be acceptable means for settling disputes and conflicts, children's education should inculcate the values of peace, tolerance, understanding and dialogue.

Children and the environment

26. Children have the greatest stake in the preservation of the environment and its judicious management for sustainable development as their survival and development depends on it. The child survival and development goals proposed for the 1990s in this Plan of Action seek to improve the environment by combating disease and malnutrition and promoting education. These contribute to lowering death rates as well as birth rates, improved social services, better use of natural resources and, ultimately, to the breaking of the vicious cycle of poverty and environmental degradation.

27. With their relatively low use of capital resources and high reliance on social mobilization, community participation and appropriate technology, the programmes designed to reach the child-related goals of the 1990s are highly compatible with and supportive of environmental protection. The goals for the survival, protection and development of children as enunciated in this Plan of Action should therefore be seen as helping to protect and preserve the environment. Still more action is needed, of course, to prevent the degradation of the environment in both the industrialized and the developing countries, through changes in the wasteful consumption patterns of the affluent and by helping to meet the necessities of survival and development of the poor. Programmes for children that not only help to meet their basic needs but which inculcate in them respect for the natural environment with the diversity of life that it sustains and its beauty and resourcefulness that enhance the quality of human life, must figure prominently in the world's environmental agenda.

Alleviation of poverty and revitalization of economic growth

28. Achievement of child related goals in the areas of health, nutrition, education, etc., will contribute much to alleviating the worst manifestations of poverty. But much more will need to be done to ensure that a solid economic base is established to meet and sustain the goals for long-term child survival, protection and development.

29. As affirmed by the international community at the eighteenth special session of the United Nations General Assembly (April 1990), a most important challenge for the 1990s is the need for revitalization of economic growth and social development in the developing countries and to address together the problems of abject poverty and hunger that continue to afflict far too many people in the world. As the most vulnerable segment of human society, children have a particular stake in sustained economic growth and alleviation of poverty, without which their well-being cannot be secured.

30. To foster a favourable international economic environment, it is essential to continue to give urgent attention to an early, broad and durable solution to the external debt problems facing developing debtor countries; to mobilize external and domestic resources to meet the increasing needs for development finance of developing countries; to take steps to ensure that the problem of the net transfer of resources from developing to developed countries does not continue in the 1990s and that its impact is effectively addressed; to create a more open and equitable trading system to facilitate the diversification and modernization of the economies of developing countries, particularly those that are commodity-dependent; and to make available substantial concessional resources, particularly for the least developed countries.

31. In all of these efforts the fulfilment of the basic needs of children must receive a high priority. Every possible opportunity should be explored to ensure that programmes benefiting children, women and other vulnerable groups are protected in times of structural adjustments and other economic restructuring. For example, as countries reduce military expenditures, part of the resources released should be channelled to programmes for social and economic development, including those benefiting children. Debt-relief schemes could be formulated in ways that the budget reallocations and renewed economic growth made possible through such schemes would benefit programmes for children. Debt relief for children, including debt swaps for investment in social development programmes, should be considered by debtors and creditors. The international community, including private-sector creditors, are urged to work with developing countries and relevant agencies to support debt relief for children. To match increased efforts by developing countries themselves, the donor countries and international institutions should consider targetting more development assistance to primary health care, basic education, low-cost water and sanitation programmes and other interventions specifically endorsed in the Summit Declaration and this Plan of Action.

32. The international community has recognized the need to stop and reverse the increasing marginalization of the least developed countries, including most countries of sub-Saharan Africa and many land-locked and island countries that face special development problems. These countries will require additional long-term international support to complement their own national efforts to meet the pressing needs of children over the 1990s.

III. Follow-up actions and monitoring

33. Effective implementation of this Plan of Action will require concerted national action and international co-operation. As affirmed in the Declaration, such action and co-operation must be guided by the principle of a "first call for children" - a principle that the essential needs of children should be given high priority in the allocation of resources, in bad times as well as in good times, at national and international as well as at family levels.

34. It is particularly important that the child-specific actions proposed must be pursued as part of strengthening broader national development programmes combining revitalized economic growth, poverty reduction, human resource development and environmental protection. Such programmes must also strengthen community organizations, inculcate civic responsibility and be sensitive to the cultural heritage and social values which support progress without alienation of the younger generation. With these broad objectives in mind, we commit ourselves and our Governments to the following actions:

Action at the national level

i) All Governments are urged to prepare, before the end of 1991, national programmes of action to implement the commitments undertaken in the World Summit Declaration and this Plan of Action. National Governments should encourage and assist provincial and local governments as well as NGOs, the private sector and civic groups to prepare their own programmes of action to help to implement the goals and objectives included in the Declaration and this Plan of Action;

ii) Each country is encouraged to re-examine in the context of its national plans, programmes and policies, how it might accord higher priority to programmes for the well-being of children in general, and for meeting over the 1990s the major goals for child survival, development and protection as enumerated in the World Summit Declaration and this Plan of Action;

iii) Each country is urged to re-examine in the context of its particular national situation, its current national budget, and in the case of donor countries, their development assistance budgets, to ensure that programmes aimed at the achievement of goals for the survival, protection and development of children will have a priority when resources are allocated. Every effort should be made to ensure that such programmes are protected in times of economic austerity and structural adjustments;

iv) Families, communities, local governments, NGOs, social, cultural, religious, business and other institutions, including the mass media, are encouraged to play an active role in support of the goals enunciated in this Plan of Action. The experience of the 1980s shows that it is only through the mobilization of all sectors of society, including those that traditionally did not consider child survival, protection and development as their major focus, that significant progress can be achieved in these areas. All forms of social mobilization, including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children;

v) Each country should establish appropriate mechanisms for the regular and timely collection, analysis and publication of data required to monitor relevant social indicators relating to the well-being of children - such as neonatal, infant and under-5 mortality rates, maternal mortality and fertility rates, nutritional levels, immunization coverage, morbidity rates of diseases of public health importance, school enrolment and achievement and literacy rates - which record the progress being made towards the goals set forth in this Plan of Action and corresponding national plans of action. Statistics should be disaggregated by gender to ensure that any inequitable impact of programmes on girls and women can be monitored and corrected. It is particularly important that mechanisms be established to alert policy makers quickly to any adverse trends to enable timely corrective action. Indicators of human development should be periodically reviewed by national leaders and decision makers, as is currently done with indicators of economic development;

vi) Each country is urged to re-examine its current arrangements for responding to natural disasters and man-made calamities which often afflict women and children the hardest. Countries that do not have adequate contingency planning for disaster preparedness are urged to establish such plans, seeking support from appropriate international institutions where necessary;

vii) Progress towards the goals endorsed in the Summit Declaration and this Plan of Action could be further accelerated, and solutions to many other major problems confronting children and families greatly facilitated, through further research and development. Governments, industry and academic institutions are requested to increase their efforts in both basic and operational research, aimed at new technical and technological breakthroughs, more effective social mobilization and better delivery of existing social services. Prime examples of the areas in which research is urgently needed include, in the field of health, improved vaccination technologies, malaria, AIDS, respiratory infections, diarrhoeal diseases, nutritional deficiencies, tuberculosis, family planning and care of the newborn. Similarly there are important research needs in the area of early child development, basic education, hygiene and sanitation, and in coping with the trauma facing children who are uprooted from their families and face other particularly difficult circumstances. Such research should involve collaboration among institutions in both the developing and the industrialized countries of the world.

Action at the international level

35. Action at the community and national levels is, of course, of critical importance in meeting the goals and aspirations for children and development. However, many developing countries, particularly the least developed and the most indebted ones, will need substantial international co-operation to enable them to participate effectively in the world-wide effort for child survival, protection and development. Accordingly, the following specific actions are proposed to create an enabling international environment for the implementation of this Plan of Action.

i) All international development agencies - multilateral, bilateral and non-governmental - are urged to examine how they can contribute to the achievement of the goals and strategies enunciated in the Declaration and this Plan of Action as part of more general attention to human development in the 1990s. They are requested to report their plans and programmes to their respective governing bodies before the end of 1991 and periodically thereafter;

ii) All regional institutions, including regional political and economic organizations, are requested to include consideration of the Declaration and this Plan of Action on the agenda of their meetings, including at the highest political level, with a view to developing agreements for mutual collaboration for implementation and ongoing monitoring;

iii) Full co-operation and collaboration of all relevant United Nations agencies and organs as well as other international institutions is requested in ensuring the achievement of the goals and objectives of the national plans envisaged in the World Summit Declaration and Plan of Action. The governing bodies of all concerned agencies are requested to ensure that within their mandates the fullest possible support is given by these agencies for the achievement of these goals;

iv) The assistance of the United Nations is requested to institute appropriate mechanisms for monitoring the implementation of this Plan of Action, using existing expertise of the relevant United Nations statistical offices, the specialized agencies, UNICEF and other United Nations organs. Furthermore, the Secretary-General of the United Nations is requested to arrange for a mid-decade review, at all appropriate levels, of the progress being made towards implementing the commitments of the Declaration and Plan of Action;

v) As the world's lead agency for children, the United Nations Children's Fund is requested to prepare, in close collaboration with the relevant specializedagencies and other United Nations organs, a consolidated analysis of the plans and actions undertaken by individual countries and the international community in support of the child-related development goals for the 1990s. The governing bodies of the relevant specialized agencies and United Nations organs are requested to include a periodic review of the implementation of the Declaration and this Plan of Action at their regular sessions and to keep the General

Assembly of the United Nations, through the Economic and Social Council, fully informed of progress to date and additional action required during the decade ahead.

36. The goals enunciated in the Declaration and this Plan of Action are ambitious and the commitments required to implement them will demand consistent and extraordinary effort on the part of all concerned. Fortunately, the necessary knowledge and techniques for reaching most of the goals already exist. The financial resources required are modest in relation to the great achievements that beckon. And the most essential factor - the provision to families of the information and services necessary to protect their children - is now within reach in every country and for virtually every community. There is no cause which merits a higher priority than the protection and development of children, on whom the survival, stability and advancement of all nations - and, indeed, of human civilization - depends. Full implementation of the Declaration and this Plan of Action must therefore be accorded a high priority for national action and international co-operation.

APPENDIX

Goals for children and development in the 1990s

The following goals have been formulated through extensive consultation in various international forums attended by virtually all Governments, the relevant United Nations agencies including the World Health Organization (WHO), UNICEF, the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme (UNDP) and the International Bank for Reconstruction and Development (IBRD) and a large number of NGOs. These goals are recommended for implementation by all countries where they are applicable, with appropriate adaptation to the specific situation of each country in terms of phasing, standards, priorities and availability of resources, with respect for cultural, religious and social traditions. Additional goals that are particularly relevant to a country's specific situation should be added in its national plan of action.

I. Major goals for child survival, development and protection

a) Between 1990 and the year 2000, reduction of infant and under-5 child mortality rate by one third or to 50 and 70 per 1,000 live births respectively, whichever is less;

b) Between 1990 and the year 2000, reduction of maternal mortality rate by half;

c) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-5 children by half;

d) Universal access to safe drinking water and to sanitary means of excreta disposal;

e) By the year 2000, universal access to basic education and completion of primary education by at least 80 per cent of primary school-age children;

f) Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level with emphasis on female literacy;

g) Improved protection of children in especially difficult circumstances.

II. Supporting/sectoral goals

A. Women's health and education

i) Special attention to the health and nutrition of the female child and to pregnant and lactating women;

ii) Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many;

iii) Access by all pregnant women to pre-natal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies;

iv) Universal access to primary education with special emphasis for girls and accelerated literacy programmes for women.

B. Nutrition

i) Reduction in severe, as well as moderate malnutrition among under-5 children by half of 1990 levels;

ii) Reduction of the rate of low birth weight (2.5 kg or less) to less than 10 per cent;

iii) Reduction of iron deficiency anaemia in women by one third of the 1990 levels;

iv) Virtual elimination of iodine deficiency disorders;

v) Virtual elimination of vitamin A deficiency and its consequences, including blindness;

vi) Empowerment of all women to breastfeed their children exclusively for four to six months and to continue breastfeeding, with complementary food, well into the second year;

vii) Growth promotion and its regular monitoring to be institutionalized in all countries by the end of the 1990s;

viii) Dissemination of knowledge and supporting services to increase food production to ensure household food security.

C. Child health

i) Global eradication of poliomyelitis by the year 2000;

ii) Elimination of neonatal tetanus by 1995;

iii) Reduction by 95 per cent in measles deaths and reduction by 90 per cent of measles cases compared to pre-immunization levels by 1995, as a major step to the global eradication of measles in the longer run;

iv) Maintenance of a high level of immunization coverage (at least 90 per cent of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child-bearing age;

v) Reduction by 50 per cent in the deaths due to diarrhoea in children under the age of five years and 25 per cent reduction in the diarrhoea incidence rate;

vi) Reduction by one third in the deaths due to acute respiratory infections in children under five years.

D. Water and Sanitation

i) Universal access to safe drinking water;

ii) Universal access to sanitary means of excreta disposal;

iii) Elimination of guinea-worm disease (dracunculiasis) by the year 2000.

E. Basic education

i) Expansion of early childhood development activities, including appropriate low-cost family- and community-based interventions;

ii) Universal access to basic education, and achievement of primary education by at least 80 per cent of primary school-age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls;

iii) Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level, with emphasis on female literacy;

iv) Increased acquisition by individuals and families of the knowledge, skills and values required for better living, made available through all educational channels, including the mass media, other forms of modern and traditional communication and social action, with effectiveness measured in terms of behavioural change.

F. Children in difficult circumstances

Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations.

Convention on the rights of the child

Convention on the rights of the child

PREAMBLE

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Convenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of

Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules); and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict,

Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child,

Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6

1. States Parties recognize that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.

4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal

relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order *(ordre public)*, public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

a) For respect of the rights or reputations of others; or

b) For the protection of national security or of public order *(ordre public)*, or of public health or morals.

Article 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the

exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.

2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order *(ordre public)*, the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. To this end, States Parties shall:

a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

c) Encourage the production and dissemination of children's books;

d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, *inter alia*, foster placement, *kafalah* of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child

permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4. States Parties shall promote, in the spirit of international co-operation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

a) To diminish infant and child mortality;

b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia,* the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

d) To ensure appropriate pre-natal and post-natal health care for mothers;

e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;

f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

a) Make primary education compulsory and available free to all;

b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

c) Make higher education accessible to all on the basis of capacity by every appropriate means;

d) Make educational and vocational information and guidance available and accessible to all children;

e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international co-operation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:

a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;

d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;

e) The development of respect for the natural environment.

2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be

hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

2. States parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

a) Provide for a minimum age or minimum ages for admission to employment;

b) Provide for appropriate regulation of the hours and conditions of employment;

c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

a) The inducement or coercion of a child to engage in any unlawful sexual activity;

b) The exploitative use of children in prostitution or other unlawful sexual practices;

c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:

a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:

a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;

b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:

i) To be presumed innocent until proven guilty according to law;

ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;

iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;

iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;

v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;

vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;

vii) To have his or her privacy fully respected at all stages of the proceedings.

3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceeding, providing that human rights and legal safeguards are fully respected.

4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

a) The law of a State Party; or

b) International law in force for that State.

PART II

Article 42

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals

and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.

7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.

9. The Committee shall elect its officers for a period of two years.

10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights:

a) Within two years of the entry into force of the Convention for the State Party concerned;

b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfillment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.

4. The Committee may request from States Parties further information relevant to the implementation of the Convention.

5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international co-operation in the field covered by the Convention:

a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from State Parties.

PART III

Article 46

The present Convention shall be open for signature by all States.

Article 47

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with

a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.

3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General.

Article 52

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

In witness thereof the undersigned plenipotentiaries, being duly authorized thereto by their respective Governments, have signed the present Convention.

II

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Economic and social statistics on the nations of the world, with particular reference to children's well-being.

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The data provided in these tables are accompanied by definitions, sources, explanations of signs and individual footnotes where the definition of the datum is different from the general definition being used. Tables derived from so many sources - nine major sources are listed in the explanatory material - will inevitably cover a wide range of data reliability. Official government data received by the responsible United Nations agency have been used whenever possible. In the many cases where there are no reliable official figures, estimates made by the responsible United Nations agency have been used. Where such internationally standardized estimates do not exist, the tables draw on data received from the appropriate UNICEF field office. Except for the indicator on access to health services and the indicators on immunization coverage, where UNICEF is identified as a main source, all data from UNICEF field office sources are marked with an * or a y.

Where possible only comprehensive or representative national data have been used. Where the data refer to only a part of the country this is indicated in a footnote.

The data for under five and infant mortality rates, life expectancy, crude birth and death rates, etc. are part of the regular work on estimates and projections undertaken by the United Nations Population Division. These and other internationally produced estimates are revised periodically, which explains why some of the data will differ from those found in earlier UNICEF publications. In the case of GNP per capita and ODA, the data are the result of a continuous process of revising and updating by the World Bank and OECD respectively.

The tables this year include data from the recently released United Nations Population Division's 1990 revision of demographic estimates. The most visible impact of these new estimates can be seen in the ordering of countries by their under five mortality rate.

So as to better reflect progress on goals for children in the 1990s, a change has been made in the boundaries which delineate the four under five mortality rate (U5MR) groups of countries in the following tables. The U5MR goal aims at a reduction of the under five mortality rate in all countries during the 1990s by one-third or to 70 per 1000 live births, whichever is less. The value of 70 under five deaths per 1000 live births is used to delineate the two higher U5MR groups of countries from the lower two groups. The other two U5MR boundaries have been determined so that a similar number of countries fall within each group. Hence, if all countries achieve the under five mortality goal, by the end of the 1990s all countries should belong to the two lowest U5MR groups.

Signs and explanations

Unless otherwise stated, the summary measures for the four U5MR (under five mortality rate) groups of countries are the median values for each group. The median is the middle value of a data set arranged in order of magnitude. It is the average commonly used where there are a large number of items of data with a great range, as is the case in these tables, and it has the advantage of not being distorted by the very small or the very large countries. In cases where the range is not so extensive, the most commonly used average is the mean, which is the sum of all the items divided by the number of items. However, because we are dealing here with countries of very different sizes and population, we would immediately encounter the problem of weighting if we used the mean. Hence the choice of median to give the reader some idea of the situation in a typical country of the appropriate U5MR group.

..	Data not available.
*	UNICEF field office source
T	Total (as opposed to a median).
x	See footnote at the end of the tables.
y	UNICEF field office source # see footnote at the end of the tables.

Figures given for the U5MR of particular countries are derived from data prepared by the UN Population Division on an internationally comparable basis using various sources. In some cases, these estimates may differ from the latest national figures. In general, data released during approximately the last 18 months are not incorporated in these estimates.

More information on the derivation of the U5MR figures can be obtained by writing to G.Jones, Senior Advisor, Information Base and Statistics, UNICEF, 3 U.N. Plaza, New York, NY 10017, U.S.A.

Index to countries

In the following tables, countries are ranked in descending order of their estimated 1989 under five mortality rate rounded to the nearest whole number. The reference numbers indicating that rank are given in the alphabetical list of countries below.

Afghanistan	2
Albania	90
Algeria	50
Angola	3
Argentina	81
Australia	120
Austria	114
Bangladesh	23
Belgium	106
Benin	34
Bhutan	19
Bolivia	31
Botswana	62
Brazil	64
Bulgaria	101
Burkina Faso	8
Burundi	18
Cambodia	17
Cameroon	35
Canada	121
Central African Rep.	11
Chad	12
Chile	93
China	80
Colombia	78
Congo	47
Costa Rica	96
Côte d'Ivoire	39
Cuba	104
Czechoslovakia	105
Denmark	115
Dominican Rep.	68
Ecuador	65
Egypt	54
El Salvador	58
Ethiopia	9
Finland	127
France	122
Gabon	29
German Dem. Rep.	123
Germany, Fed. Rep. of	116
Ghana	38
Greece	107
Guatemala	52
Guinea	7
Haiti	40
Honduras	49
Hong Kong*	125
Hungary	102
India	37
Indonesia	51
Iran, Islamic Rep. of	71
Iraq	61
Ireland	112
Israel	108
Italy	113
Jamaica	97
Japan	129
Jordan	75
Kenya	48
Korea, Dem. P. Rep. of	82
Korea, Rep. of	89
Kuwait	98
Lao People's Dem. Rep.	33
Lebanon	74
Lesotho	41
Liberia	15
Libyan Arab Jamahiriya	45
Madagascar	24
Malawi	6
Malaysia	91
Mali	4
Mauritania	14
Mauritius	92
Mexico	77
Mongolia	63
Morocco	46
Mozambique	1
Myanmar	56
Namibia	27
Nepal	20
Netherlands	126
New Zealand	109
Nicaragua	55
Niger	10
Nigeria	28
Norway	117
Oman	76
Pakistan	32
Panama	87
Papua New Guinea	67
Paraguay	73
Peru	44
Philippines	69
Poland	99
Portugal	103
Romania	86
Rwanda	16
Saudi Arabia	53
Senegal	22
Sierra Leone	5
Singapore	111
Somalia	13
South Africa	57
Spain	118
Sri Lanka	83
Sudan	25
Sweden	128
Switzerland	124
Syrian Arab Rep.	72
Tanzania, U. Rep. of	26
Thailand	84
Togo	36
Trinidad and Tobago	100
Tunisia	70
Turkey	59
Uganda	30
United Arab Emirates	88
United Kingdom	119
Uruguay	95
USA	110
USSR	85
Venezuela	79
Viet Nam	66
Yemen, Rep. of	21
Yugoslavia	94
Zaire	42
Zambia	43
Zimbabwe	60

*Colony

TABLE 1: BASIC INDICATORS

		Under 5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no of births (thousands)	Annual no of under 5 deaths (thousands)	GNP per capita (US $)	Life expectancy at birth (years)	Total adult literacy rate	% of age group enrolled in primary school Total	% share of household income 1976-1988	
		1960	1989	1960	1989	1989	1989	1989	1988	1989	1985	1986-1988	lowest 40%	highest 20%
	Very high U5MR countries (over 140) Median	**299**	**193**	**183**	**118**	**1511T**	**57399T**	**9764T**	**295**	**49**	**32**	**66**	..	..
1	Mozambique	331	**297**	190	173	15.2	683	203	100	47	28	68	..	..
2	Afghanistan	381	**296**	215	169	15.7	776	230	280^x	42	24	21	..	..
3	Angola	345	**292**	208	173	9.7	460	134	1130^x	45	36	93	..	..
4	Mali	369	**287**	210	166	8.9	456	131	230	45	23	23	..	..
5	Sierra Leone	385	**261**	219	151	4.0	195	51	240	42	13	58	..	..
6	Malawi	366	**258**	207	147	8.4	475	123	170	48	..	66	..	..
7	Guinea	336	**241**	203	142	5.6	284	68	430	43	17	30	..	..
8	Burkina Faso	363	**232**	205	135	8.8	412	96	210	48	15	32	..	..
9	Ethiopia	294	**226**	175	133	47.9	2383	539	120	45	66^y	37	..	..
10	Niger	321	**225**	191	132	7.5	387	87	300	45	22	29	..	..
11	Central African Rep.	308	**219**	183	129	3.0	134	29	380	49	32	66	..	..
12	Chad	325	**219**	195	129	5.5	245	54	160	46	23	51	..	..
13	Somalia	294	**218**	175	129	7.3	358	78	170	46	17	..	..	..
14	Mauritania	321	**217**	191	124	2.0	91	20	480	47	28	52	..	..
15	Liberia	310	**209**	184	137	2.5	118	25	450^x	53	32	35	..	..
16	Rwanda	248	**201**	146	119	7.0	356	72	320	49	45	67	..	..
17	Cambodia	218	**200**	146	127	8.1	324	65	..	50	29	..	..	..
18	Burundi	260	**196**	153	116	5.3	254	50	240	48	42	67	..	..
19	Bhutan	298	**193**	187	125	1.5	57	11	180	49	32	26	..	..
20	Nepal	298	**193**	187	125	18.7	721	139	180	52	22	76	13	59
21	Yemen	378	**192**	214	116	11.3	587	113	600	51	32	86	..	..
22	Senegal	299	**189**	172	85	7.1	321	61	650	48	32	60	..	..
23	Bangladesh	262	**184**	156	116	112.5	4659	857	170	51	32	70	22	39
24	Madagascar	364	**179**	220	117	11.6	532	95	190	54	77	94	..	..
25	Sudan	292	**175**	170	105	24.5	1083	190	480	50	24	49	..	..
26	Tanzania	249	**173**	147	103	26.3	1329	230	160	54	91^y	66	16^x	50^x
27	Namibia	262	**171**	155	103	1.7	76	13	..	57	..	..	..	..
28	Nigeria	316	**170**	190	102	105.0	5083	864	290	51	43	64	..	..
29	Gabon	287	**167**	171	100	1.1	47	8	2970	52	56	..	..	..
30	Uganda	223	**167**	133	100	18.1	942	157	280	52	43	70	..	..
31	Bolivia	282	**165**	167	105	7.1	302	50	570	54	73	91	12	58
32	Pakistan	276	**162**	163	106	118.8	5452	883	350	57	31	40	19	46
33	Laos	233	**156**	155	106	4.0	181	28	180	49	..	94	..	..
34	Benin	310	**150**	185	89	4.5	221	33	390	47	19	63	..	..
35	Cameroon	275	**150**	163	92	11.4	547	82	1010	53	48	109	..	..
36	Togo	305	**150**	182	92	3.4	153	23	370	54	38	101	..	..
37	India	282	**145**	165	96	835.6	26071	3780	340	59	44	98	20	41
38	Ghana	224	**143**	132	87	14.6	644	92	400	55	53	71	17	45
	High U5MR countries (71-140) Median	**230**	**94**	**143**	**67**	**886T**	**28685T**	**2777T**	**830**	**61**	**67**	**99**	**13**	**53**
39	Côte d'Ivoire	264	**139**	165	93	11.6	575	80	770	53	49	..	13	53
40	Haiti	270	**133**	182	94	6.4	230	31	380	55	48	78	6	48
41	Lesotho	208	**132**	149	97	1.7	70	9	420	57	..	115	..	..
42	Zaire	269	**132**	158	81	34.5	1574	208	170	53	66	76	..	..
43	Zambia	228	**125**	135	78	8.1	417	52	290	54	67	97	11	61
44	Peru	233	**119**	142	84	21.1	633	75	1300	62	82	..	13	52
45	Libyan Arab Jamahiriya	269	**116**	160	78	4.4	191	22	5420	61	57	..	..	..
46	Morocco	265	**116**	163	78	24.4	855	99	830	61	42	71	23	39
47	Congo	241	**112**	143	71	2.2	102	11	930	53	52	..	..	..
48	Kenya	208	**111**	124	70	23.2	1062	118	370	59	65	96	9	60
49	Honduras	232	**103**	144	66	5.0	195	20	860	65	68	106	..	..
50	Algeria	270	**102**	168	70	24.3	826	84	2360	65	49	96	..	..
51	Indonesia	225	**100**	139	73	180.8	4991	499	440	61	72	118	21	41
52	Guatemala	230	**97**	125	56	8.9	359	35	900	63	52	77	14	55
53	Saudi Arabia	292	**95**	170	67	13.6	568	54	6200	64	58	71	..	..
54	Egypt	301	**94**	179	67	51.2	1737	163	660	60	45	90	21	41
55	Nicaragua	209	**92**	140	59	3.7	154	14	830^x	64	78*	99	..	..
56	Myanmar	230	**91**	153	67	40.8	1204	110	220^x	61	78	81	..	..
57	South Africa	192	**91**	135	69	34.5	1097	100	2290	61	..	..	..	..
58	El Salvador	207	**90**	143	61	5.1	184	17	940	64	69	79	16	47
59	Turkey	258	**90**	190	73	54.8	1566	141	1280	65	76	117	12^x	57^x
60	Zimbabwe	181	**90**	110	63	9.4	389	35	650	59	62	128	..	..
61	Iraq	222	**89**	139	65	18.3	770	69	2340^x	64	52	98	..	..
62	Botswana	173	**87**	119	64	1.3	61	5	1010	59	70	114	9	59
63	Mongolia	185	**87**	128	66	2.1	76	7	780^x	62	..	102	..	..

Note: nations are listed in descending order of their 1989 under five mortality rates (shown in bold type)

		Under 5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births (thousands)	Annual no. of under 5 deaths (thousands)	GNP per capita (US $)	Life expectancy at birth (years)	Total adult literacy rate	% of age group enrolled in primary school Total	% share of household income 1976-1988	
		1960	1989	1960	1989	1989	1989	1989	1988	1989	1985	1986-1988	lowest 40%	highest 20%
64	Brazil	159	**85**	116	61	147.4	4127	351	2160	65	79	103	8	63
65	Ecuador	184	**85**	124	61	10.3	333	28	1120	66	83	117	. .	. .
66	Viet Nam	232	**84**	156	61	65.3	2016	169	240[x]	62	84	101	. .	. .
67	Papua New Guinea	248	**83**	165	58	3.8	128	11	810	55	47	70	. .	. .
68	Dominican Rep.	199	**80**	125	63	7.0	215	17	720	66	80	101	. .	. .
69	Philippines	134	**72**	80	44	60.9	1980	143	630	64	88	106	15	48
	Middle U5MR countries (21-70) Median	**121**	**36**	**86**	**27**	**1894T**	**41921T**	**1790T**	**1725**	**70**	**86**	**105**	**14**	**51**
70	Tunisia	254	**66**	159	51	8.0	242	16	1230	66	58	116	. .	. .
71	Iran, Islamic Rep. of	254	**64**	169	50	53.4	1756	112	3530[x]	67	48	114	. .	. .
72	Syria	217	**62**	135	46	12.1	535	33	1140	66	59	110	. .	. .
73	Paraguay	134	**61**	86	41	4.2	143	9	1180	67	88	102	. .	. .
74	Lebanon	91	**57**	68	45	2.7	87	5	2150[x]	65	77	125	. .	. .
75	Jordan	217	**55**	135	42	3.9	152	8	1500	67	74	99	. .	. .
76	Oman	378	**53**	214	40	1.4	65	3	5000	65	30[x]	97	. .	. .
77	Mexico	140	**51**	92	41	86.7	2446	125	1760	69	85	118	10	58
78	Colombia	157	**50**	99	39	32.3	870	44	1180	69	85	114	13	52
79	Venezuela	114	**44**	81	35	19.2	577	25	3250	70	86	107	14	51
80	China	203	**43**	150	31	1122.4	24580	1057	330	70	68	132	. .	. .
81	Argentina	75	**36**	61	31	31.9	667	24	2520	71	95	110	14[x]	50[x]
82	Korea, Dem.	120	**36**	85	27	21.4	513	18	970[x]	70	. .	. .	. .	. .
83	Sri Lanka	114	**36**	71	27	17.0	360	13	420	71	87	104	13	56
84	Thailand	149	**35**	103	27	54.9	1137	40	1000	66	91	95	15	50
85	USSR	53	**35**	38	25	286.5	5214	182	4550[x]	71	. .	106	. .	. .
86	Romania	82	**34**	69	27	23.2	357	12	2560[x]	70	. .	97	. .	. .
87	Panama	105	**33**	69	23	2.4	62	2	2120	72	86	106	7[x]	62[x]
88	United Arab Emirates	239	**31**	145	25	1.5	33	1	15770	70	. .	99	. .	. .
89	Korea, Rep.	120	**31**	85	24	42.4	639	20	3600	70	95	104	17	45
90	Albania	151	**30**	112	25	3.2	74	2	790[x]	72	. .	100	. .	. .
91	Malaysia	105	**30**	73	23	17.4	556	17	1940	70	74	102	14	51
92	Mauritius	104	**29**	70	22	1.1	19	1	1800	70	. .	106	12	46
93	Chile	143	**27**	114	20	13.0	307	8	1510	72	92	102	13	54
94	Yugoslavia	113	**27**	92	24	23.7	339	9	2520	72	91	95	17	43
95	Uruguay	57	**27**	51	23	3.1	54	1	2470	72	95	110	. .	. .
96	Costa Rica	121	**22**	84	18	2.9	81	2	1690	75	92	98	12	55
97	Jamaica	89	**21**	63	16	2.4	56	1	1070	73	98	105	15	49
	Low U5MR countries (20 and under) Median	**38**	**11**	**32**	**9**	**889T**	**11721T**	**131T**	**12575**	**76**	**92**	**103**	**18**	**40**
98	Kuwait	128	**20**	89	17	2.0	53	1	13400	73	71	94	. .	. .
99	Poland	70	**18**	62	16	38.2	596	11	1860	72	. .	101	24	35
100	Trinidad and Tobago	67	**18**	54	15	1.3	33	1	3350	71	. .	100	13	50
101	Bulgaria	69	**17**	49	14	9.0	111	2	4150[x]	72	. .	104	. .	. .
102	Hungary	57	**17**	51	16	10.6	119	2	2460	70	. .	97	26	32
103	Portugal	112	**16**	81	13	10.3	134	2	3650	74	82	127	15[x]	49[x]
104	Cuba	87	**14**	62	11	10.5	189	3	1170[x]	76	92	104	. .	. .
105	Czechoslovakia	33	**13**	27	11	15.6	214	3	5820[x]	71	. .	96	. .	. .
106	Belgium	35	**12**	31	10	9.8	116	1	14490	75	. .	100	22	36
107	Greece	64	**12**	53	11	10.0	114	1	4800	76	91	106	. .	. .
108	Israel	39	**12**	33	10	4.5	100	1	8650	76	. .	95	18	40
109	New Zealand	26	**12**	23	10	3.4	55	1	10000	75	. .	107	16	45
110	USA	29	**12**	26	10	247.3	3685	44	19840	76	. .	100	16	42
111	Singapore	49	**12**	36	8	2.7	49	1	9070	74	. .	116	15	49
112	Ireland	36	**11**	31	9	3.7	65	1	7750	74	. .	100	20	39
113	Italy	50	**11**	44	10	57.1	554	6	13330	76	96	95	19	41
114	Austria	43	**10**	37	8	7.6	86	1	15470	75	. .	101	. .	. .
115	Denmark	25	**10**	22	8	5.1	57	1	18450	76	. .	99	17	39
116	Germany, Fed.	39	**10**	33	8	61.3	668	7	18480	75	. .	103	20	39
117	Norway	22	**10**	19	8	4.2	52	1	19990	77	. .	95	19	37
118	Spain	57	**10**	47	9	39.1	457	5	7740	77	94	113	19	40
119	United Kingdom	27	**10**	23	8	57.1	788	8	12810	76	. .	106	17	40
120	Australia	25	**9**	21	8	16.7	246	2	12340	76	. .	106	16	42
121	Canada	33	**9**	28	7	26.3	363	3	16960	77	. .	105	18	40
122	France	34	**9**	29	8	56.0	761	7	16090	76	. .	113	18	41
123	Germany, Dem.	45	**9**	38	8	16.3	204	2	7180[x]	74	. .	106	. .	. .
124	Switzerland	26	**9**	22	7	6.6	78	1	27500	77	. .	. .	17	45
125	Hong Kong	64	**8**	44	7	5.8	67	1	9220	77	. .	106	16	. .
126	Netherlands	21	**8**	18	7	14.9	192	2	14520	77	. .	115	20	38
127	Finland	28	**7**	22	6	5.0	61	0	18590	75	. .	101	18	38
128	Sweden	20	**7**	16	6	8.4	113	1	19300	77	. .	100	21	37
129	Japan	39	**6**	31	4	123.0	1341	8	21020	79	. .	102	22	38

TABLE 2: NUTRITION

		% of infants with low birth-weight 1980-88	% of mothers breast-feeding 1980-88			% of children (1980-89) suffering from: underweight (0-4 years)		wasting (12-23 months)	stunting (24-59 months)	Average index of food production per capita (1979-81=100) 1989	Daily per capita calorie supply as % of requirements 1984-86	% of household income (1980-85) spent on	
			3 months	6 months	12 months	moderate & severe	severe	moderate & severe	moderate & severe			all food	cereals
	Very High U5MR countries (over 140) Median	**17**	**92**	**90**	**76**	**35**	**6**	**15**	**43**	**92**	**91**	**53**	**22**
1	Mozambique	20*	99*	96*	..	57*	8*	..	..	82	69	..	..
2	Afghanistan	20	..	..	..	..	..	..	..	..	94	..	..
3	Angola	17^{x}	..	..	..	..	..	..	..	80	82	..	..
4	Mali	17*	91*	..	82*	31^{x}	9^{x}	16	34^{x}	99	86	57	22
5	Sierra Leone	17*	99*	98*	92*	23^{x}	2^{x}	14^{x}	..	87	81	56	22
6	Malawi	20*	..	..	96	24	..	8	61	86	102	55	28
7	Guinea	..	100*	90*	85*	..	..	..	..	88	77	..	..
8	Burkina Faso	..	98*	98*	97*	..	..	..	..	114	86	..	..
9	Ethiopia	..	..	97*	95*	38^{x}	..	19^{x}	43^{x}	91	71	50	24
10	Niger	15	65	30	15	49	..	23^{x}	38^{x}	84	100	..	..
11	Central African Rep.	15*	..	..	..	..	..	..	..	90	86	..	..
12	Chad	..	..	..	..	..	..	..	..	98	69	..	..
13	Somalia	..	92*	78*	54*	..	..	..	..	97	90	..	..
14	Mauritania	11	91	86	67	31	..	24^{x}	37^{x}	87	92	..	..
15	Liberia	..	96*	92*	70*	..	..	..	..	92	102	..	..
16	Rwanda	17^{x}	97*	97*	74*	..	..	..	..	72	81	30	11
17	Cambodia	..	100	93	72	20*	3*	..	..	145	98	..	..
18	Burundi	9^{x}	..	95*	90*	38^{x}	10^{x}	10	60^{x}	88	97	..	..
19	Bhutan	..	90*	90*	90*	38^{x}	..	4^{x}	56^{x}	121	..	..	..
20	Nepal	..	92^{x}	92^{x}	82^{x}	..	..	..	..	106	93	57	38
21	Yemen	..	74^{x}	66^{x}	34^{x}	53^{x}	..	15^{x}	61^{x}	92	..	..	..
22	Senegal	11^{x}	94^{x}	94^{x}	82^{x}	22^{x}	6^{x}	8	28^{x}	103	99	50	15
23	Bangladesh	28	91^{x}	86^{x}	82^{x}	71^{x}	31^{x}	28	70	98	83	59	36
24	Madagascar	10*	95*	95*	85*	33^{x}	8^{x}	17	56^{x}	92	106	59	26
25	Sudan	..	91*	86*	72*	41*	8*	13^{x}	..	83	88	60	..
26	Tanzania	14	100*	90*	70*	48*	6*	17*	..	90	96	64	32
27	Namibia	..	..	..	..	..	..	..	..	92	82	..	..
28	Nigeria	20*	98*	80*	60*	..	..	21^{x}	..	95	90	52	18
29	Gabon	..	..	..	..	..	..	..	..	79	107	..	..
30	Uganda	..	85*	70*	20*	23^{x}	5^{x}	4	25^{x}	85	95	..	..
31	Bolivia	12*	..	..	..	13^{x}	3^{x}	2	51^{x}	100	89	33	..
32	Pakistan	25*	87*	74*	51*	52^{x}	10^{x}	17^{x}	42^{x}	105	97	54	17
33	Laos	39	..	99^{y}	93^{y}	37	..	20	44	120	104	..	..
34	Benin	8*	90	90	76	..	..	..	..	122	95	37	12
35	Cameroon	13^{x}	92^{x}	90^{x}	77^{x}	17^{x}	..	2^{x}	43^{x}	95	88	24	8
36	Togo	20	99*	90*	58*	24^{x}	6^{x}	10	37^{x}	93	97	..	..
37	India	30	..	..	..	41^{x}	6^{x}	..	..	118	100	52	18
38	Ghana	17*	91	90	72	27	6	15	39	111	76	50	..
	High U5MR countries (71-140) Median	**14**	**89**	**84**	**73**	**16**	**2**	**7**	**34**	**96**	**109**	**40**	**12**
39	Côte d'Ivoire	14^{x}	87	84	78	12	2	17	20	92	110	40	14
40	Haiti	17^{x}	..	92*	80*	37^{x}	3^{x}	17^{x}	51^{x}	89	84	..	..
41	Lesotho	11	..	87*	..	16	2	7	23	72	101	..	..
42	Zaire	13	100*	100*	86*	..	..	..	..	92	98	55	15
43	Zambia	14^{x}	..	..	93	28*	..	..	..	96	92	37	8
44	Peru	9*	82*	71*	55*	13	2	3	43	98	93	35	8
45	Libyan Arab Jamahiriya	..	..	..	..	..	..	..	..	110	153	..	..
46	Morocco	..	87*	81*	70*	16^{x}	4^{x}	6	34^{x}	125	118	40	12
47	Congo	16*	100*	98*	90*	17	3	10	23	96	117	42	19
48	Kenya	15	86^{x}	82^{x}	67^{x}	..	..	10	42^{x}	103	92	39	16
49	Honduras	20	83*	55*	..	21	4	2^{x}	34^{x}	89	92	39	..
50	Algeria	9*	..	..	..	10^{x}	..	4	14^{x}	93	112	..	..
51	Indonesia	14	98*	97*	76*	51^{x}	1^{x}	11*	46*	124	116	48	21
52	Guatemala	14*	97*	93*	83*	34^{x}	8^{x}	3	68^{x}	104	105	36	10
53	Saudi Arabia	6^{x}	91*	52*	..	..	..	..	..	252	125	..	..
54	Egypt	5	90	87	81	13^{x}	3^{x}	2	32^{x}	107	132	50	10
55	Nicaragua	15	..	..	71	11	1	..	22	59	110	..	..
56	Myanmar	16*	..	..	..	38^{x}	..	17	75^{x}	120	119	..	..
57	South Africa	12^{x}	..	..	..	..	..	..	..	93	120	26	..
58	El Salvador	15*	84*	77*	55*	15*	..	..	..	87	94	33	12
59	Turkey	7*	99*	91*	51*	12*	1*	..	..	92	125	40	8
60	Zimbabwe	15^{x}	98	96	84	12^{x}	2^{x}	2	31^{x}	94	89	40	9
61	Iraq	9*	76	45	19	..	..	..	..	99	124	..	..
62	Botswana	8*	96	93	73	15	..	19^{x}	51^{x}	69	96	35	13
63	Mongolia	10	..	..	..	..	..	..	..	90	116	..	..

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		% of infants with low birth-weight 1980-88	% of mothers breast-feeding 1980-88			% of children (1980-89) suffering from				Average index of food production per capita (1979-81=100) 1989	Daily per capita calorie supply as % of requirements 1984-86	% of household income (1980-85) spent on	
			3 months	6 months	12 months	underweight (0-4 years) moderate & severe	underweight (0-4 years) severe	wasting (12-23 months) moderate & severe	stunting (24-59 months) moderate & severe			all food	cereals
64	Brazil	8*	66	58	34	5ˣ	. .	2ˣ	31ˣ	117	111	35	9
65	Ecuador	11*	86	74	48	17	0	4	39	109	89	30	. .
66	Viet Nam	18*	. .	. .	. .	42	14	12	60ˣ	113	105	. .	. .
67	Papua New Guinea	25ˣ	. .	. .	. .	35	. .	. .	. .	96	96	. .	. .
68	Dominican Rep.	16*	. .	. .	. .	13ˣ	2ˣ	3	26ˣ	99	109	46	13
69	Philippines	18*	. .	74*	. .	33	2ˣ	7	42	88	104	51	20
	Middle U5MR countries (21-70) Median	**8**	**79**	**55**	**36**	**16**	**2**	**7**	**23**	**99**	**122**	**35**	**7**
70	Tunisia	8*	95*	92*	71*	10ˣ	2ˣ	4	23ˣ	89	123	37	7
71	Iran, Islamic Rep. of	5	. .	. .	. .	43ˣ	. .	23ˣ	55ˣ	80	138	37	10
72	Syria	11*	88ˣ	72ˣ	41ˣ	25*	2*	. .	. .	64	131	. .	. .
73	Paraguay	7	80*	70*	45*	32*	1*	. .	. .	120	123	30	6
74	Lebanon	10	50*	40*	15*	. .	. .	. .	. .	. .	125	. .	. .
75	Jordan	5ˣ	80*	70*	50*	. .	. .	. .	. .	105	121	35	. .
76	Oman	7*	75*	55*	20*	. .	. .	. .	. .	. .	. .	. .	. .
77	Mexico	15ˣ	62ˣ	52ˣ	36ˣ	. .	. .	. .	. .	100	135	35	. .
78	Colombia	8*	80*	55*	36*	12ˣ	2ˣ	1	27ˣ	105	110	29	. .
79	Venezuela	9	50ˣ	40ˣ	30ˣ	6ˣ	. .	4ˣ	7ˣ	78	102	38	. .
80	China	9*	65*	55*	. .	21ˣ	3ˣ	8ˣ	41ˣ	129	111	61	. .
81	Argentina	. .	66	36	14	. .	. .	. .	. .	85	136	35	4
82	Korea, Dem.	. .	. .	. .	. .	. .	. .	. .	. .	108	135	. .	. .
83	Sri Lanka	28	95	81	68	38ˣ	9ˣ	19	34ˣ	87	110	43	18
84	Thailand	12	83	79	68	26ˣ	4ˣ	10	28ˣ	108	105	30	7
85	USSR	6	. .	. .	. .	. .	. .	. .	. .	113	133	. .	. .
86	Romania	6	. .	. .	. .	. .	. .	. .	. .	107	127	. .	. .
87	Panama	8	62	53	. .	16	. .	7	24	88	107	38	7
88	United Arab Emirates	7ˣ	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
89	Korea, Rep.	9	58ˣ	40ˣ	27ˣ	. .	. .	. .	. .	99	122	35	14
90	Albania	7	. .	. .	. .	. .	. .	. .	. .	96	114	. .	. .
91	Malaysia	10	88*	. .	. .	. .	. .	. .	. .	153	121	30	. .
92	Mauritius	9*	79	55	40	24	. .	16ˣ	22ˣ	94	121	24	7
93	Chile	7	81*	57*	20*	3ˣ	. .	1	10ˣ	111	106	29	7
94	Yugoslavia	7	. .	. .	. .	. .	. .	. .	. .	97	139	27	. .
95	Uruguay	8*	50*	43*	. .	7ˣ	2ˣ	. .	16ˣ	113	100	31	7
96	Costa Rica	10	61	38	22	6	. .	3	8	89	124	33	8
97	Jamaica	8*	95	82	43	7	1	6	7	81	116	39	. .
	Low U5MR countries (20 and under) Median	**6**	**47**	**25**	**. .**	**. .**	**. .**	**. .**	**. .**	**103**	**129**	**16**	**2**
98	Kuwait	7	47ˣ	32ˣ	12ˣ	6	. .	2	14	. .	. .	. .	. .
99	Poland	8	32ˣ	25ˣ	. .	. .	. .	. .	. .	106	126	29	. .
100	Trinidad and Tobago	. .	59*	50*	14*	7ˣ	0	5	4ˣ	96	126	. .	. .
101	Bulgaria	6	. .	. .	. .	. .	. .	. .	. .	102	145	. .	. .
102	Hungary	10	86	. .	. .	. .	. .	. .	. .	113	135	25	. .
103	Portugal	5	29	12	7	. .	. .	. .	. .	111	128	34	. .
104	Cuba	8	. .	. .	. .	. .	. .	1ˣ	. .	108	135	. .	. .
105	Czechoslovakia	6	. .	. .	. .	. .	. .	. .	. .	122	141	. .	. .
106	Belgium	5	. .	. .	. .	. .	. .	. .	. .	118	146	15	2
107	Greece	6	. .	. .	. .	. .	. .	. .	. .	102	147	30	. .
108	Israel	7	. .	. .	. .	. .	. .	. .	. .	102	118	22	. .
109	New Zealand	5	. .	. .	. .	. .	. .	. .	. .	103	129	12	2
110	USA	7	33	24	. .	. .	. .	. .	. .	95	138	13	2
111	Singapore	7	. .	. .	. .	14ˣ	. .	4ˣ	11ˣ	93	124	19	. .
112	Ireland	4	. .	. .	. .	. .	. .	. .	. .	103	146	22	4
113	Italy	7ˣ	. .	. .	. .	. .	. .	. .	. .	100	139	19	2
114	Austria	6	41	. .	. .	. .	. .	. .	. .	106	130	16	2
115	Denmark	6	. .	. .	. .	. .	. .	. .	. .	123	131	13	2
116	Germany, Fed.	6	. .	. .	. .	. .	. .	. .	. .	109	130	12	2
117	Norway	4	. .	. .	. .	. .	. .	. .	. .	111	120	15	2
118	Spain	1	. .	. .	. .	. .	. .	. .	. .	109	137	24	3
119	United Kingdom	7	26	22	. .	. .	. .	. .	. .	104	128	12	2
120	Australia	6ˣ	56	40	10	. .	. .	. .	. .	96	125	13	2
121	Canada	6	53	30	. .	. .	. .	. .	. .	103	129	11	2
122	France	5	. .	. .	. .	. .	. .	. .	. .	102	130	16	2
123	Germany, Dem.	6	. .	. .	. .	. .	. .	. .	. .	113	145	. .	. .
124	Switzerland	5ˣ	. .	. .	. .	. .	. .	. .	. .	101	128	17	. .
125	Hong Kong	5	. .	. .	. .	. .	. .	. .	. .	67	121	12	1
126	Netherlands	. .	33ˣ	. .	. .	. .	. .	. .	. .	111	121	13	2
127	Finland	4	. .	7ˣ	. .	. .	. .	. .	. .	110	113	16	3
128	Sweden	4	47	23	. .	. .	. .	. .	. .	98	113	13	2
129	Japan	5	72	52	. .	. .	. .	. .	. .	96	122	16	4

TABLE 3: HEALTH

		% of population with access to safe water 1985-88			% of population with access to health services 1985-88			Percentage fully immunized 1981/1988-89					ORT use rate 1987-88
								one-year-old children				pregnant women	
		total	urban	rural	total	urban	rural	TB	DPT	Polio	Measles	Tetanus	
	Very high U5MR countries (over 140) Median	**44**	**72**	**22**	**46**	**90**	**36**	**24/74**	**14/47**	**8/49**	**23/48**	**5/32**	**23**
1	Mozambique	16	38	9	39	100	30	46/51	56/39	32/39	32/48	. ./43	14
2	Afghanistan	21	38	17	29	80	17	8/38	3/33	3/33	6/22	3/20	11
3	Angola	30	87	15	30^x	. .	. .	. ./46	. ./18	. ./19	. ./42	. ./23	12
4	Mali	17	46	10	15	. .	. .	19/85	. ./26	. ./26	. ./40	1/38	3
5	Sierra Leone	25	68	7	. .	. .	. .	35/74	15/34	13/34	28/37	10/79	31
6	Malawi	56	97	50	80	. .	. .	86/96	66/90	68/89	65/84	. ./72	14
7	Guinea	19	41	12	47	100	40	4/31	. ./16	. ./16	15/27	5/6	1
8	Burkina Faso	67	43	69	49^x	51^x	48^x	16/83	2/49	2/49	23/72	11/51	16
9	Ethiopia	16	69	9	46	. .	. .	10/44	6/26	7/26	7/23	. ./24	38
10	Niger	47	35	49	41	99	30	28/25	6/12	6/11	19/12	3/18	35
11	Central African Rep.	. .	13	. .	45	. .	. .	. ./91	. ./59	. ./56	. ./62	. ./40	15
12	Chad	. .	. .	. .	30	. .	. .	. ./59	. ./20	. ./20	. ./32	. ./42	2
13	Somalia	34	58	22	27^x	50^x	15^x	3/31	2/18	2/18	3/30	5/21	12
14	Mauritania	. .	73	. .	30^x	. .	. .	57/79	18/28	18/28	45/45	1/21	23
15	Liberia	55	100	23	39	50	30	87/62	39/28	26/28	99/55	60/20	9
16	Rwanda	50	79	48	27^x	60^x	25^x	51/92	17/84	15/83	42/83	5/87	24
17	Cambodia	3	10	2	53	80	50	. ./42	. ./22	. ./22	. ./20	. ./22	6
18	Burundi	26	98	21	61	. .	. .	65/99	38/82	6/82	30/73	25/80	30
19	Bhutan	. .	. .	19	65	. .	. .	38/86	13/70	11/76	21/36	. ./42	40
20	Nepal	29	70	25	. .	. .	. .	32/84	16/67	1/67	2/54	4/26	28
21	Yemen	45	97	26	38	. .	. .	14/71	21/53	21/53	33/45	. ./8	7
22	Senegal	53	79	38	40	. .	. .	. ./85	. ./47	. ./53	. ./48	. ./37	27
23	Bangladesh	46	24	49	45	. .	. .	1/89	1/49	1/49	. ./52	1/57	32
24	Madagascar	32	81	17	56	. .	. .	25/71	40/45	. ./42	. ./40	. ./12	80
25	Sudan	21	60	10	51	90	40	3/65^x	1/52^x	1/52^x	1/43^x	1/32^x	25
26	Tanzania	56	90	42	76^x	99^x	72^x	78/93	58/85	49/82	76/83	36/48	14
27	Namibia	. .	. .	. .	. .	. .	. .	. ./. .	. ./. .	. ./. .	. ./. .	. ./. .	. .
28	Nigeria	46	100	20	40	75	30	23/72	24/58	24/57	55/59	11/21	35
29	Gabon	92^x	. .	. .	90^x	. .	. .	. ./95	. ./65	. ./65	. ./68	. ./54	10
30	Uganda	20	37	18	61^x	90^x	57^x	18/77	9/40	8/41	22/49	20/14	14
31	Bolivia	44	75	13	63	90	38	30/70	13/40	15/50	17/70	. ./20	26
32	Pakistan	44	83	27	55	99	35	11/78	3/73	3/73	2/64	1/31	42
33	Laos	21	28	20	67	. .	. .	4/29	7/21	7/22	7/20	2/4	30
34	Benin	52	80	34	18	. .	. .	. ./74	. ./42	. ./42	. ./41	. ./60	26
35	Cameroon	33	43	24	41	44	39	8/69	5/53	5/51	16/48	. ./32	24
36	Togo	55	99	41	61	. .	. .	44/91	9/55	9/55	47/62	57/63	21
37	India	57	76	50	. .	. .	. .	12/89	31/83	7/82	. ./69	24/69	23
38	Ghana	56	93	39	60	92	45	67/99	22/51	25/51	23/65	11/19	21
	High U5MR countries (71-140) Median	**52**	**75**	**33**	**75**	**100**	**60**	**61/81**	**42/76**	**42/78**	**33/69**	**10/41**	**39**
39	Côte d'Ivoire	19	30	10	30^x	61^x	11^x	70/47	42/42	34/42	28/41	25/34	16
40	Haiti	38	59	30	50	. .	. .	60/40	14/50	3/50	. ./31	. ./5	35
41	Lesotho	36	65	30	80	. .	. .	81/78	56/77	54/81	49/75	. ./. .	68
42	Zaire	33	52	21	26	40	17	34/54	18/38	18/38	23/40	. ./24	18
43	Zambia	59	76	41	75^x	100^x	50^x	72/92	44/83	77/81	21/80	. ./45	59
44	Peru	55	73	17	60	. .	. .	63/61	18/58	18/59	24/52	4/12	10
45	Libyan Arab Jamahiriya	97	100	90	. .	. .	. .	55/90	55/84	55/84	57/70	6/9	60
46	Morocco	60	100	25	70	100	50	. ./91	43/79	45/79	. ./82	. ./45	45
47	Congo	21	42	7	83	97	70	92/90	42/79	42/79	49/75	. ./47	6
48	Kenya	30	61	21	. .	. .	. .	. ./90	. ./77	. ./78	. ./65	. ./62	54
49	Honduras	50	56	45	73	85	65	46/75	38/77	37/83	38/86	11/16	66
50	Algeria	68	85	55	88	100	80	59/98	33/81	30/81	17/73	. ./. .	16
51	Indonesia	38	43	36	80	. .	. .	55/85	. ./75	. ./77	. ./68	10/41	56
52	Guatemala	38	72	14	34	47	25	29/38	42/51	42/57	8/52	1/18	17
53	Saudi Arabia	97	100	88	97	100	88	49/97	53/96	52/96	12/86	. ./50	32
54	Egypt†	73	92	56	. .	. .	. .	71/75	82/81	84/81	65/83	10/58	83
55	Nicaragua	49	76	11	83	100	60	65/90	23/64	52/82	20/61	. ./25	38
56	Myanmar	27	36	24	33	100	11	15/66	5/50	. ./46	. ./50	6/42	21
57	South Africa	. .	. .	. .	. .	. .	. .	. ./. .	. ./. .	. ./. .	. ./. .	. ./. .	. .
58	El Salvador	52	68	40	56	80	40	47/62	42/64	38/72	44/73	20/19	45
59	Turkey	78	95	63	. .	. .	. .	42/16	64/74	69/74	52/67	. ./15	. .
60	Zimbabwe	. .	. .	32	71	100	62	64/80	39/76	38/75	56/70	. ./58	26
61	Iraq	87	100	54	93	97	78	76/94	13/83	16/83	33/82	4/56	51
62	Botswana	54	84	46	89^x	100^x	85^x	80/99	64/89	71/88	68/80	32/79	64
63	Mongolia	. .	. .	. .	. .	. .	. .	53/92	99/84	99/85	. ./86	. ./. .	59

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		% of population with access to safe water 1985-88			% of population with access to health services 1985-88			Percentage fully immunized 1981/1988-89					ORT use rate 1987-88
								one-year-old children				pregnant women	
		total	urban	rural	total	urban	rural	TB	DPT	Polio	Measles	Tetanus	
64	Brazil	78	85	56	. .	. .	. .	62/70	47/54	99/97	73/58	. ./. .	39
65	Ecuador	58	81	31	75	92	40	82/91	26/54	19/63	31/56	4/5	24
66	Viet Nam	46	70	39	80	100	75	. ./80	. ./68	. ./68	. ./71	. ./. .	17
67	Papua New Guinea	27	95	15	96	. .	. .	64/82	50/53	32/52	. ./52	. ./50	46
68	Dominican Rep.	63	85	33	80	. .	. .	34/40	27/46	42/75	17/46	26/24	51
69	Philippines	52	49	54	. .	. .	. .	61/89	51/79	44/78	. ./83	37/43	14
	Middle U5MR countries (21-70) Median	**83**	**95**	**64**	**82**	**96**	**73**	**65/92**	**52/87**	**51/89**	**46/82**	**6/54**	**30**
70	Tunisia	68	100	31	90[x]	100[x]	80[x]	65/82	36/93	37/93	65/92	2/32	48
71	Iran, Islamic Rep. of	76	95	55	80	95	65	6/90	29/88	47/89	48/89	2/56	38
72	Syria	75[x]	98[x]	54[x]	75[x]	92[x]	60[x]	36/98	14/93	14/93	14/86	3/93	31
73	Paraguay	29	53	8	60[x]	90[x]	38[x]	42/58	28/67	26/71	16/58	6/54	36
74	Lebanon	93	95	85	. .	. .	. .	. ./. .	. ./. .	. ./. .	. ./. .	. ./. .	10
75	Jordan	96	100	88	97	98	95	. ./. .	81/94	87/94	40/84	2/26	53
76	Oman	53	90	49	91	100	90	49/92	9/96	9/96	6/94	27/70	19
77	Mexico	77	89	47	45[x]	. .	. .	41/80	41/65	85/96	33/85	. ./. .	72
78	Colombia	92	100	76	60	. .	. .	57/90	20/75	22/92	26/73	6/40	12
79	Venezuela	90	93	65	. .	. .	. .	77/68	54/55	75/67	43/49	. ./. .	30
80	China	. .	85	. .	. .	. .	. .	. ./98	. ./95	. ./96	. ./95	. ./. .	30
81	Argentina	56	63	17	71	80	21	63/93	46/74	38/81	73/78	. ./. .	13
82	Korea, Dem.	. .	. .	. .	. .	. .	. .	52/99	52/94	51/96	31/97	. ./. .	52
83	Sri Lanka	40	82	29	93[x]	. .	. .	58/97	45/89	49/87	. ./81	48/39	77
84	Thailand	64	56	66	70	85	80	71/98	52/84	22/84	. ./66	27/70	30
85	USSR	. .	. .	. .	. .	. .	. .	. ./93[x]	95/79[x]	95/80[x]	95/79[x]	. ./. .	. .
86	Romania	. .	. .	. .	. .	. .	. .	. ./95[x]	. ./96	. ./95	. ./79	. ./. .	. .
87	Panama	83	100	64	80[x]	95[x]	64[x]	77/90	49/71	50/71	53/75	. ./27	41
88	United Arab Emirates	. .	. .	. .	90[x]	. .	. .	18/92	45/84	45/84	42/66	. ./. .	13
89	Korea, Rep.	77	90	48	93	97	86	42/86	61/86	62/87	5/96	. ./. .	. .
90	Albania	. .	. .	. .	. .	. .	. .	93/94	94/96	92/94	90/96	. ./. .	. .
91	Malaysia	84	96	76	. .	. .	. .	91/99	54/72	61/72	. ./50	20/54	20
92	Mauritius	100	100	100	100	100	100	87/90	82/87	82/88	. ./82	1/63	7
93	Chile	94	98	71	97	. .	. .	100/95	97/95	96/95	93/91	. ./. .	1
94	Yugoslavia	. .	. .	. .	. .	. .	. .	99/89	90/91	95/92	95/93	. ./. .	. .
95	Uruguay	85	95	27	82	. .	. .	76/97	57/82	58/82	95/75	18/13	40
96	Costa Rica	91	100	83	80[x]	100[x]	63[x]	81/87	83/88	85/91	71/88	. ./90	78
97	Jamaica	96	99	93	90	. .	. .	. ./100	39/85	37/84	. ./71	50/50	15
	Low U5MR countries (20 and under) Median	**. .**	**. .**	**. .**	**. .**	**. .**	**. .**	**96/90**	**85/90**	**90/94**	**70/85**	**. ./. .**	**. .**
98	Kuwait	. .	97	. .	100	. .	. .	. ./3	54/92	76/92	66/93	30/. .	4
99	Poland	. .	. .	. .	. .	. .	. .	95/95	95/98	95/99	65/96	. ./. .	. .
100	Trinidad and Tobago	98	100	95	99	. .	. .	. ./. .	52/77	55/77	. ./59	. ./60	60
101	Bulgaria	. .	. .	. .	. .	. .	. .	97/99	97/99	98/99	98/99	98/. .	. .
102	Hungary	. .	. .	. .	. .	. .	. .	99/99	99/99	98/99	99/99	. ./. .	. .
103	Portugal	. .	. .	. .	. .	. .	. .	74/86	75/91	16/92	70/100	. ./. .	. .
104	Cuba	. .	. .	. .	. .	. .	. .	97/96	67/94	82/94	49/97	. ./. .	75
105	Czechoslovakia	. .	. .	. .	. .	. .	. .	95/99	95/99	95/99	95/91	. ./. .	. .
106	Belgium	. .	. .	. .	. .	. .	. .	. ./. .	95/80	99/95	50/75	. ./. .	. .
107	Greece	. .	. .	. .	. .	. .	. .	95/. .	95/83	95/98	. ./82	. ./. .	. .
108	Israel	. .	. .	. .	. .	. .	. .	70/. .	84/87	91/93	69/86	. ./. .	. .
109	New Zealand	. .	. .	. .	. .	. .	. .	. ./20[x]	72/69[x]	. ./75[x]	. ./67[x]	. ./. .	. .
110	USA	. .	. .	. .	. .	. .	. .	. ./. .	. ./97	. ./97	96/98	. ./. .	. .
111	Singapore	100	100	. .	100	100	. .	83/99	87/90	88/90	57/87[x]	. ./90	. .
112	Ireland	. .	. .	. .	. .	. .	. .	. ./80[x]	36/43	76/72	. ./68	. ./. .	. .
113	Italy	. .	. .	. .	. .	. .	. .	. ./30	. ./85[x]	. ./85	. ./50	. ./. .	. .
114	Austria	. .	. .	. .	. .	. .	. .	90/90	90/90	90/90	90/60	. ./. .	. .
115	Denmark	. .	. .	. .	. .	. .	. .	95/. .	85/88	97/100	. ./80	. ./. .	. .
116	Germany, Fed.	. .	. .	. .	. .	. .	. .	40/79	50/94[x]	80/94	35/47	. ./. .	. .
117	Norway	. .	. .	. .	. .	. .	. .	. ./. .	. ./87	. ./84	. ./84	. ./. .	. .
118	Spain	. .	. .	. .	. .	. .	. .	. ./. .	. ./73	. ./73	. ./84	. ./. .	. .
119	United Kingdom	. .	. .	. .	. .	. .	. .	. ./75	44/75	71/87	52/80	. ./. .	. .
120	Australia	. .	. .	. .	. .	. .	. .	. ./. .	. ./. .	. ./. .	. ./68[x]	. ./. .	. .
121	Canada	. .	. .	. .	. .	. .	. .	. ./. .	. ./85[x]	. ./85[x]	. ./85[x]	. ./. .	. .
122	France	. .	. .	. .	. .	. .	. .	80/80	79/95	80/95	. ./60	. ./. .	. .
123	Germany, Dem.	. .	. .	. .	. .	. .	. .	95/99	80/95	90/97	95/98	. ./. .	. .
124	Switzerland	. .	. .	. .	. .	. .	. .	. ./90[x]	. ./90	. ./98	. ./90	. ./. .	. .
125	Hong Kong	99[x]	. .	. .	99[x]	. .	. .	99/94	84/88	94/96	. ./33	. ./. .	. .
126	Netherlands	. .	. .	. .	. .	. .	. .	. ./. .	97/94	97/94	93/93	. ./. .	. .
127	Finland	. .	. .	. .	. .	. .	. .	90/91	92/90	90/90	70/95	. ./. .	. .
128	Sweden	. .	. .	. .	. .	. .	. .	. ./14	99/99[x]	99/98[x]	56/94	. ./. .	. .
129	Japan	. .	. .	. .	. .	. .	. .	85/85[x]	. ./83[x]	. ./. .	. ./73[x]	. ./. .	. .

TABLE 4: EDUCATION

		Adult literacy rate				No. of sets per 1000 population 1986-87		Primary school enrolment ratio						% of grade 1 enrolment completing primary school 1985-87	Secondary school enrolment ratio 1986-88 (gross)	
		1970		1985				1960 (gross)		1986-88 (gross)		1986-88 (net)				
		male	female	male	female	radio	television	male	female	male	female	male	female		male	female
	Very high U5MR countries (over 140) Median	**28**	**8**	**45**	**19**	**99**	**6**	**36**	**16**	**73**	**50**	**51**	**38**	**50**	**23**	**9**
1	Mozambique	29	14	39	16	38	1	60	36	76	59	49	41	39	7	4
2	Afghanistan	13	2	38	9	102	8	15	2	27	14	..	..	63	10	5
3	Angola	16	7	50	23	49	5	..	..	..	..	..	..	..	..	..
4	Mali	11	4	31	15	37	..	14	6	29	17	23	14	39	9	4
5	Sierra Leone	18	8	21	6	216	8	30	..	68	48	..	..	..	23	11
6	Malawi	42	18	..	..	197	..	..	45	73	59	50	47	33	5	3
7	Guinea	21	7	26	8	33	2	44	16	41	18	31	15	70	13	4
8	Burkina Faso	13	3	23	6	24	5	12	5	41	24	34	20	74	8	4
9	Ethiopia	8	..	..	..	193	2	11	3	46	28	32	22	41*	18	12
10	Niger	6	2	32	11	62	3	7	3	37	20	..	..	75	..	..
11	Central African Rep.	26	6	45	19	60	2	53	12	82	51	59	39	17	17	6
12	Chad	20	2	34	13	237	1	29	4	73	29	52	23	17	10	2
13	Somalia	5	1	27	9	38	0	13	13	..	..	19	10	33*	..	..
14	Mauritania	..	..	40	16	139	1	13	3	61	42	..	..	92	23	9
15	Liberia	27	8	43	21	224	18	45	18	82	50	..	..	..	..	..
16	Rwanda	43	21	59	32	54	..	..	..	69	66	65	63	49	7	5
17	Cambodia	..	..	41	17	106	8	..	..	..	..	..	..	50*	45*	20*
18	Burundi	29	10	53	32	56	0	27	9	68	50	46	37	87	6	3
19	Bhutan	..	..	45	19	15	..	5	..	31	20	..	..	..	7	2
20	Nepal	23	3	34	11	31	1	19	1	104	47	76	35	27	35	11
21	Yemen	14	3	47*	21*	60	11	..	..	132	39	..	..	31*	42	7
22	Senegal	18	5	45	19	103	32	36	..	71	49	59	41	83	19	10
23	Bangladesh	36	12	45	19	40	3	66	26	76	64	67	44	20	24	11
24	Madagascar	56	43	86	68	193	6	58	45	97	92	89	..	30*	23	19
25	Sudan	28	6	39	10	229	52	35	14	59	41	..	..	61*	23	17
26	Tanzania	48	18	93^{y}	88^{y}	16	1	33	18	67	66	50	51	76	5	3
27	Namibia	..	..	..	..	123	11	..	..	..	..	..	..	..	..	..
28	Nigeria	35	14	55	31	163	6	46	27	..	..	..	..	63*	..	..
29	Gabon	43	22	70	43	119	23	..	..	..	..	..	..	59	..	..
30	Uganda	52	30	57	29	96	6	..	32	76	63	43	38	76	16	9
31	Bolivia	68	46	81	65	527	77	78	50	97	85	88	78	..	40	35
32	Pakistan	30	11	43	18	86	14	46	13	51	28	..	..	49^{y}	26	11
33	Laos	37	28	..	..	123	2	34	16	102	85	..	..	14*	23	16
34	Benin	23	8	26	12	75	4	38	15	84	43	66	34	36	23	9
35	Cameroon	47	19	61	36	125	12	87	43	119	100	..	..	67	32	20
36	Togo	27	7	51	25	178	5	63	24	124	78	87	59	59	36	12
37	India	47	20	58	29	77	7	80	40	113	81	..	..	..	50	27
38	Ghana	43	18	64	42	292	13	52	25	78	63	..	..	..	49	32
	High U5MR countries (71-140) Median	**58**	**44**	**73**	**55**	**145**	**54**	**74**	**62**	**102**	**94**	**81**	**79**	**66**	**44**	**37**
39	Côte d'Ivoire	26	10	63	34	131	54	68	24	..	..	..	..	68	26	12
40	Haiti	26^{x}	17^{x}	54	42	41	4	50	42	83	72	45	42	15	19	17
41	Lesotho	49	74	..	..	68	1	63	102	102	127	..	..	52	18	26
42	Zaire	61	22	79	53	98	1	88	32	84	68	81^{x}	63^{x}	60	32	14
43	Zambia	66	37	77	59	73	15	51	34	102	92	..	..	91	..	..
44	Peru	81	60	90	75	241	84	95	71	125	120	..	..	51*	68	61
45	Libyan Arab Jamahiriya	60	13	70	40	221	63	92	24	..	..	..	..	82	..	..
46	Morocco	34	10	54	30	206	56	67	27	85	56	68	46	69	43	30
47	Congo	50	19	66	38	120	3	103	53	..	..	..	..	75	..	..
48	Kenya	44	19	77	53	90	6	64	30	98	93	..	..	62	27	19
49	Honduras	55	50	71	65	376	67	68	67	104	108	..	..	43	..	..
50	Algeria	39	11	63	35	227	70	55	37	105	87	97	81	90	61	46
51	Indonesia	66	42	80	64	145	40	86	58	120	115	99	97	80	..	..
52	Guatemala	51	37	60	44	65	37	50	39	82	70	..	..	36	..	..
53	Saudi Arabia	15	2	69	43	272	268	22	..	78	65	64	48	90	52	35
54	Egypt	50	20	60	30	310	83	80	52	100	79	..	..	64	79	58
55	Nicaragua	58	57	..	..	237	60	65	66	94	104	74	79	20	29	58
56	Myanmar	85	57	88	69	79	1	61	52	..	..	..	..	27*	..	..
57	South Africa	..	..	..	..	319	97	94	85	..	..	..	..	..	..	..
58	El Salvador	61	53	73	65	401	82	..	..	77	81	61	62	31	27	30
59	Turkey	69	34	88	64	160	172	90	58	121	113	..	..	85*	57	34
60	Zimbabwe	63	47	70	55	85	22	..	..	130	126	100	100	74	49	42
61	Iraq	50	18	64	41	199	64	94	36	105	91	91	82	71	60	38
62	Botswana	37	44	82	60	130	7	35	48	111	117	85	93	89	31	33
63	Mongolia	87	74	..	..	128	31	79	78	100	103	..	..	..	88	96

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		Adult literacy rate				No. of sets per 1000 population 1986-87		Primary school enrolment ratio						% of grade 1 enrolment completing primary school 1985-87	Secondary school enrolment ratio 1986-88 (gross)	
		1970		1985				1960 (gross)		1986-88 (gross)		1986-88 (net)				
		male	female	male	female	radio	television	male	female	male	female	male	female		male	female
64	Brazil	69	63	80	77	368	191	97	93	. .	. .	. .	. .	22	32	41
65	Ecuador	75	68	86	81	292	81	87	79	118	116	. .	. .	50^{*}	55	57
66	Viet Nam	. .	. .	90	80	99	34	. .	. .	107	94	. .	. .	50^{*}	44	41
67	Papua New Guinea	39	24	60	32	64	2	59	7	75	64	. .	. .	67^{*}	16	9
68	Dominican Rep.	69	65	82	79	164	79	99	98	99	103	80	78	35	. .	. .
69	Philippines	84	81	88	87	135	36	98	93	105	107	94	94	75	66	66
	Middle U5MR countries (21-70) Median	**83**	**74**	**88**	**85**	**261**	**114**	**100**	**92**	**105**	**104**	**92**	**89**	**81**	**56**	**59**
70	Tunisia	44	17	68	47	171	68	88	43	126	107	100	89	77	46	34
71	Iran, Islamic Rep. of	40	17	59	36	236	53	56	27	122	105	98	89	83	57	39
72	Syria	60	20	74	44	231	58	89	39	115	104	100	94	67^{*}	69	48
73	Paraguay	85^{x}	75^{x}	91	86	165	24	105	90	104	99	86	84	50	30	30
74	Lebanon	79^{x}	58^{x}	86	69	772	302	105	99	105	95	. .	. .	. .	57	56
75	Jordan	64	29	86	62	237	69	94	59	98	99	88	88	96	80	78
76	Oman	. .	. .	. .	. .	649	739	. .	. .	103	92	83	77	89	46	29
77	Mexico	78	69	88	82	241	120	82	77	119	116	. .	. .	71	54	53
78	Colombia	79	76	86	84	167	108	77	77	112	115	72	74	57	55	56
79	Venezuela	79	71	84	88	395	142	100	100	107	107	. .	. .	73	48	59
80	China	. .	. .	80	55	184	17	. .	. .	140	124	99^{*}	95^{*}	68^{*}	50	37
81	Argentina	94	92	95	94	659	217	98	99	110	110	. .	. .	. .	69	78
82	Korea, Dem.	. .	. .	. .	. .	110	12	. .	. .	. .	. .	. .	. .	99	. .	. .
83	Sri Lanka	85	69	92	81	187	31	100	90	105	102	100	100	88	63	69
84	Thailand	86	72	95	87	174	103	88	79	. .	. .	. .	. .	64^{*}	. .	. .
85	USSR	98	97	. .	. .	685	314	100	100	. .	. .	. .	. .	80	. .	. .
86	Romania	96	91	. .	. .	288	166	101	95	. .	. .	. .	. .	. .	79	80
87	Panama	81	81	87	86	220	163	98	94	109	104	90	89	82	56	63
88	United Arab Emirates	24	7	. .	. .	319	106	. .	. .	98	100	88	89	82	55	66
89	Korea, Rep.	94	81	98	91	986	194	99	89	104	104	100	99	99	91	86
90	Albania	. .	. .	. .	. .	167	83	102	86	100	99	. .	. .	. .	80	71
91	Malaysia	71	48	83	65	436	140	108	83	102	102	. .	. .	97	59	59
92	Mauritius	77	59	. .	. .	263	188	103	93	105	107	93	95	96	53	50
93	Chile	90	88	93	92	335	163	111	107	103	101	. .	. .	33^{*}	72	76
94	Yugoslavia	92	76	97	85	344	175	113	108	95	94	. .	. .	98	82	79
95	Uruguay	93^{x}	93^{x}	96	95	594	173	111	111	111	109	. .	. .	86	. .	. .
96	Costa Rica	88	87	92	92	258	79	97	95	100	97	85	85	81	40	43
97	Jamaica	96	97	98	98	400	108	92	93	104	106	. .	. .	. .	62	67
	Low U5MR countries (20 and under) Median	**94**	**88**	**. .**	**. .**	**610**	**368**	**106**	**104**	**104**	**102**	**97**	**97**	**95**	**89**	**92**
98	Kuwait	65	42	75	63	327	261	131	102	95	92	81	77	91	86	79
99	Poland	98	97	. .	. .	289	263	110	107	101	101	99	99	94	78	82
100	Trindad and Tobago	. .	. .	. .	. .	457	290	. .	. .	. .	. .	. .	. .	. .	. .	. .
101	Bulgaria	94	89	. .	. .	357	189	94	92	105	103	. .	. .	90	75	76
102	Hungary	98	98	. .	. .	586	402	103	100	97	97	94	96	92	69	70
103	Portugal	78	65	86	77	212	159	132	129	131	123	. .	. .	. .	47	56
104	Cuba	86	87	94	91	334	193	109	109	107	100	95	94	92	85	92
105	Czechoslovakia	. .	. .	. .	. .	577	281	93	93	95	96	. .	. .	93	27	49
106	Belgium	99	99	. .	. .	465	320	111	108	99	100	82	83	77	99	100
107	Greece	93	76	97	86	411	175	104	101	106	106	91	92	99	89	80
108	Israel	93	83	. .	. .	470	264	99	97	94	97	. .	. .	. .	79	87
109	New Zealand	. .	. .	. .	. .	923	369	110	106	107	106	100	100	. .	84	86
110	USA	99	99	. .	. .	2119	811	. .	. .	101	100	97	97	. .	98	99
111	Singapore	92	55	. .	. .	306	. .	121	113	118	113	100	100	95	70	73
112	Ireland	. .	. .	. .	. .	580	. .	107	112	100	100	. .	. .	. .	91	101
113	Italy	95	93	97	96	786	. .	112	109	. .	. .	97	98	99	. .	. .
114	Austria	. .	. .	. .	. .	561	480	106	104	102	101	. .	. .	95	78	81
115	Denmark	. .	. .	. .	. .	956	386	103	103	98	99	. .	. .	99	106	107
116	Germany, Fed.	. .	. .	. .	. .	954	385	. .	. .	101	101	. .	. .	95	96	92
117	Norway	. .	. .	. .	. .	790	348	100	100	95	95	97	97	99	92	97
118	Spain	93	87	97	92	295	368	106	116	113	113	98	98	96	97	107
119	United Kingdom	. .	. .	. .	. .	1145	434	92	92	105	106	97	97	. .	82	85
120	Australia	. .	. .	. .	. .	1270	483	103	103	106	105	97	98	. .	96	99
121	Canada	. .	. .	. .	. .	953	577	108	105	106	104	97	97	. .	104	104
122	France	99	98	. .	. .	893	. .	144	143	114	113	100	100	95	89	96
123	Germany, Dem.	. .	. .	. .	. .	663	754	111	113	107	105	92	91	. .	79	76
124	Switzerland	. .	. .	. .	. .	834	405	118	118	. .	. .	. .	. .	. .	. .	. .
125	Hong Kong	90^{x}	64^{x}	. .	. .	633	241	93	79	106	105	95	95	98	71	76
126	Netherlands	. .	. .	. .	. .	908	469	105	104	114	116	85	88	94	105	103
127	Finland	. .	. .	. .	. .	991	. .	100	95	102	101	. .	. .	98	98	114
128	Sweden	. .	. .	. .	. .	875	39	95	96	. .	. .	. .	. .	. .	90	92
129	Japan	99	99	. .	. .	863	587	103	102	102	102	100	100	99	95	97

TABLE 5: DEMOGRAPHIC INDICATORS

		Population (millions) 1989		Population annual growth rate (%)		Crude death rate		Crude birth rate		Life expectancy		Total fertility rate 1989	% population urbanized 1989	Average annual growth rate of urban population (%)	
		under 16	under 5	1965-80	1980-89	1960	1989	1960	1989	1960	1989			1965-80	1980-89
	Very high U5MR countries (over 140) Median	**647T**	**238T**	**2.5**	**2.9**	**26**	**16**	**48**	**47**	**38**	**48**	**6.6**	**28**	**5.9**	**5.7**
1	Mozambique	7.0	2.7	2.5	2.6	26	18	47	45	37	47	6.4	25	11.8	10.0
2	Afghanistan	7.1	2.8	2.4	-0.3	30	23	52	49	33	42	6.9	19	6.0	1.6
3	Angola	4.6	1.8	2.8	2.6	31	20	50	47	33	45	6.4	28	6.4	5.7
4	Mali	4.4	1.7	2.1	2.9	29	20	52	51	35	45	7.1	19	4.9	4.0
5	Sierra Leone	1.9	0.7	2.0	2.4	33	23	48	48	32	42	6.5	32	4.3	5.2
6	Malawi	4.3	1.7	2.9	3.5	28	20	54	56	38	48	7.6	12	7.8	6.1
7	Guinea	2.7	1.1	1.9	2.5	31	22	53	51	34	43	7.0	25	6.6	5.6
8	Burkina Faso	4.0	1.6	2.0	2.6	28	18	52	47	36	48	6.5	9	3.4	5.1
9	Ethiopia	22.9	9.0	2.7	2.4	28	20	51	50	36	45	6.9	13	6.6	4.5
10	Niger	3.7	1.5	2.7	3.3	29	20	53	52	35	45	7.1	19	6.9	7.3
11	Central African Rep.	1.4	0.5	1.8	2.7	26	17	43	46	39	49	6.2	46	4.8	4.7
12	Chad	2.5	1.0	2.0	2.4	30	19	46	44	35	46	5.9	29	9.2	6.3
13	Somalia	3.5	1.4	2.7	3.4	28	20	49	49	36	46	6.6	36	6.1	5.8
14	Mauritania	0.9	0.4	2.3	2.7	28	19	48	46	35	47	6.5	45	12.4	7.6
15	Liberia	1.2	0.5	3.0	3.2	25	16	50	47	41	53	6.8	45	6.2	6.0
16	Rwanda	3.6	1.4	3.3	3.4	22	17	50	51	42	49	8.2	7	6.3	7.8
17	Cambodia	2.9	1.3	0.3	2.6	21	16	45	40	42	50	4.6	11	1.9	3.8
18	Burundi	2.5	1.0	1.9	2.8	23	18	46	48	41	48	6.8	5	1.8	5.5
19	Bhutan	0.6	0.2	1.6	1.9	25	16	43	38	38	49	5.5	5	3.7	5.0
20	Nepal	8.3	3.0	2.4	2.6	26	14	46	39	38	52	5.8	9	5.1	7.2
21	Yemen	5.8	2.3	2.3	3.5	28	15	53	52	36	51	7.7	28	6.4	7.2
22	Senegal	3.4	1.3	2.5	2.8	27	17	50	45	37	48	6.4	38	4.1	3.8
23	Bangladesh	52.5	18.8	2.7	2.7	23	15	47	41	40	51	5.3	16	8.0	6.6
24	Madagascar	5.5	2.1	2.5	3.1	24	14	48	46	41	54	6.6	23	5.7	5.8
25	Sudan	11.6	4.4	3.0	3.0	25	15	47	44	39	50	6.4	22	5.1	4.1
26	Tanzania	13.5	5.4	3.3	3.7	24	14	51	51	41	54	7.1	31	8.7	10.9
27	Namibia	0.8	0.3	..	3.1	23	12	46	44	42	57	6.1	27	..	5.2
28	Nigeria	52.1	20.5	2.5	3.2	25	15	52	48	40	51	6.9	35	4.8	5.9
29	Gabon	0.4	0.2	3.5	3.8	24	16	31	41	41	52	5.1	45	4.2	6.3
30	Uganda	9.4	3.8	2.9	3.6	21	15	50	52	43	52	7.3	10	4.1	5.4
31	Bolivia	3.3	1.2	2.5	2.7	22	14	46	42	43	54	6.0	51	2.9	4.2
32	Pakistan	56.5	22.5	3.1	3.7	24	12	49	46	43	57	6.4	32	4.3	5.0
33	Laos	1.8	0.7	0.6	2.5	23	16	45	45	40	49	6.7	18	4.8	5.9
34	Benin	2.2	0.9	2.7	2.9	33	19	47	49	35	47	7.1	37	10.2	4.8
35	Cameroon	5.6	2.2	2.7	3.1	25	14	44	48	39	53	7.0	40	8.1	5.8
36	Togo	1.6	0.6	3.0	3.0	26	14	48	45	39	54	6.6	25	7.2	6.2
37	India	324.5	113.4	2.3	2.2	21	11	43	31	44	59	4.2	27	3.6	3.8
38	Ghana	6.9	2.7	2.2	3.4	19	13	48	44	45	55	6.4	33	3.4	4.1
	High U5MR countries (71-140) Median	**367T**	**236T**	**2.6**	**2.8**	**20**	**9**	**47**	**36**	**48**	**61**	**5.2**	**44**	**4.6**	**4.3**
39	Côte d'Ivoire	5.8	2.3	4.2	3.8	25	14	53	50	39	53	7.4	40	8.7	5.4
40	Haiti	2.7	1.0	2.0	1.9	24	13	42	36	42	55	4.9	28	4.0	3.7
41	Lesotho	0.8	0.3	2.3	2.8	24	12	43	41	42	57	5.8	20	14.6	6.9
42	Zaire	16.7	6.4	2.8	3.0	23	14	47	46	41	53	6.1	39	7.2	4.5
43	Zambia	4.2	1.7	3.1	3.9	23	13	50	51	42	54	7.2	49	7.1	6.3
44	Peru	8.5	2.8	2.8	2.2	19	9	47	30	48	62	3.8	70	4.1	3.1
45	Libyan Arab Jamahiriya	2.1	0.8	4.6	4.1	19	9	49	44	47	61	6.8	69	9.0	6.3
46	Morocco	10.5	3.7	2.5	2.6	21	9	50	35	47	61	4.6	47	4.2	4.2
47	Congo	1.1	0.4	2.7	3.1	23	14	45	46	42	53	6.3	40	3.5	4.3
48	Kenya	12.2	4.6	3.6	3.7	23	11	53	46	45	59	6.7	23	9.0	7.6
49	Honduras	2.4	0.9	3.2	3.4	19	8	51	39	46	65	5.4	43	5.5	5.4
50	Algeria	11.3	3.8	3.1	2.9	20	8	51	34	47	65	5.2	51	3.8	4.7
51	Indonesia	69.7	22.7	2.3	2.0	23	9	44	28	41	61	3.3	30	4.7	5.3
52	Guatemala	4.3	1.6	2.8	2.8	20	8	49	40	46	63	5.7	39	3.6	3.4
53	Saudi Arabia	6.5	2.5	4.6	4.1	23	7	49	42	44	64	7.1	77	8.5	5.7
54	Egypt	21.2	7.5	2.4	2.5	21	10	45	34	46	60	4.4	46	2.9	3.1
55	Nicaragua	1.8	0.7	3.1	3.4	18	8	51	41	47	64	5.4	59	4.6	4.5
56	Myanmar	16.3	5.5	2.3	2.1	21	9	42	30	44	61	3.8	25	2.8	2.4
57	South Africa	13.6	4.8	2.4	2.2	17	10	42	32	49	61	4.4	59	2.6	3.5
58	El Salvador	2.4	0.8	2.7	1.4	16	8	49	36	51	64	4.8	44	3.5	2.1
59	Turkey	20.3	7.0	2.4	2.3	18	8	45	29	50	65	3.6	60	4.3	5.8
60	Zimbabwe	4.5	1.7	3.1	3.1	20	10	53	41	45	59	5.7	27	7.5	5.5
61	Iraq	8.9	3.3	3.4	3.5	20	8	49	42	49	64	6.3	71	5.3	4.3
62	Botswana	0.6	0.3	3.5	3.7	21	11	52	48	46	59	7.1	26	15.4	9.9
63	Mongolia	0.9	0.3	3.0	2.8	18	8	43	36	47	62	4.9	52	4.5	3.0

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		Population (millions) 1989		Population annual growth rate (%)		Crude death rate		Crude birth rate		Life expectancy		Total fertility rate 1989	% population urbanized 1989	Average annual growth rate of urban population (%)	
		under 16	under 5	1965-80	1980-89	1960	1989	1960	1989	1960	1989			1965-80	1980-89
64	Brazil	55.3	18.8	2.4	2.2	13	8	43	28	55	65	3.4	74	4.5	3.4
65	Ecuador	4.4	1.5	3.1	2.7	15	7	46	32	53	66	4.1	55	5.1	4.5
66	Viet Nam	27.3	9.3	..	2.2	23	9	42	31	44	62	3.9	22	4.1	3.4
67	Papua New Guinea	1.6	0.6	2.3	2.3	23	11	44	34	41	55	5.2	16	8.4	4.2
68	Dominican Rep.	2.8	1.0	2.7	2.3	16	7	50	31	52	66	3.6	60	5.3	4.1
69	Philippines	25.9	9.1	2.9	2.6	15	8	46	33	53	64	4.2	42	4.0	3.9
	Middle U5MR countries (21-70) Median	**582T**	**127T**	**2.4**	**2.0**	**13**	**7**	**43**	**24**	**58**	**70**	**3.0**	**55**	**3.9**	**3.0**
70	Tunisia	3.2	1.1	2.1	2.5	19	7	47	30	48	66	3.9	54	4.2	2.9
71	Iran, Islamic Rep. of	24.7	8.3	3.2	3.5	21	7	47	33	50	67	5.1	56	5.5	4.8
72	Syria	6.1	2.3	3.4	3.5	18	7	47	44	50	66	6.6	50	4.5	4.3
73	Paraguay	1.8	0.6	2.8	3.1	9	7	43	35	64	67	4.5	47	3.2	4.4
74	Lebanon	1.0	0.4	1.6	0.0	14	9	43	32	60	65	3.8	84	4.6	1.2
75	Jordan	1.8	0.7	2.6	3.1	23	6	50	39	47	67	6.0	68	5.3	4.5
76	Oman	0.7	0.3	3.6	4.3	28	6	51	45	40	65	7.2	10	8.1	8.1
77	Mexico	35.0	11.5	3.1	2.3	12	6	46	28	57	69	3.4	72	4.5	3.2
78	Colombia	12.5	4.1	2.2	2.1	13	6	45	27	57	69	3.0	69	3.5	3.0
79	Venezuela	7.8	2.7	3.5	2.8	10	5	45	30	60	70	3.7	90	4.5	3.6
80	China	327.4	108.5	2.2	1.3	19	7	37	22	47	70	2.5	32	2.6	6.8
81	Argentina	10.2	3.2	1.6	1.4	9	9	24	21	65	71	2.9	86	2.2	1.8
82	Korea, Dem.	6.8	2.3	2.7	1.8	13	5	42	24	54	70	2.4	60	4.6	2.3
83	Sri Lanka	5.9	1.9	1.8	1.5	9	6	36	21	62	71	2.5	21	2.3	1.4
84	Thailand	19.5	5.8	2.7	1.8	15	7	44	21	52	66	2.3	22	4.6	4.5
85	USSR	77.2	25.3	0.9	0.8	7	11	24	18	68	71	2.4	66	2.2	1.3
86	Romania	5.9	1.7	1.1	0.5	9	11	20	15	65	70	2.1	52	3.4	1.2
87	Panama	0.9	0.3	2.6	2.1	10	5	41	26	61	72	3.0	53	3.4	2.9
88	United Arab Emirates	0.5	0.2	16.1	4.7	19	4	46	22	53	70	4.7	78	18.9	4.2
89	Korea, Rep.	12.1	3.4	1.9	1.2	14	6	43	15	54	70	1.5	71	5.7	3.6
90	Albania	1.1	0.4	2.5	2.0	10	6	41	23	62	72	2.9	35	3.4	2.4
91	Malaysia	7.0	2.6	2.5	2.6	15	6	44	32	54	70	3.9	42	4.5	4.9
92	Mauritius	0.3	0.1	1.6	1.1	10	7	44	18	59	70	1.9	41	4.0	0.7
93	Chile	4.2	1.5	1.8	1.7	13	6	37	24	57	72	2.7	86	2.6	2.3
94	Yugoslavia	5.8	1.7	0.9	0.7	10	9	24	14	63	72	1.9	55	3.0	2.8
95	Uruguay	0.9	0.3	0.4	0.6	10	10	22	17	68	72	2.4	85	0.7	0.8
96	Costa Rica	1.1	0.4	2.6	2.8	10	4	47	28	62	75	3.2	47	3.7	3.7
97	Jamaica	0.9	0.3	1.5	1.4	10	7	39	23	63	73	2.4	52	3.4	2.6
	Low U5MR countries (20 and under) Median	**193T**	**191T**	**0.7**	**0.5**	**9**	**10**	**19**	**13**	**70**	**76**	**1.7**	**77**	**1.8**	**1.2**
98	Kuwait	0.7	0.3	7.0	4.0	10	2	44	27	60	73	3.6	95	8.2	4.6
99	Poland	10.2	3.1	0.8	0.8	8	10	24	16	67	72	2.2	61	1.8	1.4
100	Trinidad and Tobago	0.5	0.2	1.3	1.7	9	6	38	26	64	71	2.9	68	5.0	3.7
101	Bulgaria	2.0	0.6	0.5	0.2	9	12	18	12	68	72	1.9	67	2.8	1.2
102	Hungary	2.3	0.6	0.4	-0.1	10	13	16	11	68	70	1.7	61	1.8	1.2
103	Portugal	2.4	0.7	0.6	0.6	11	10	24	13	63	74	1.7	33	2.0	1.9
104	Cuba	2.7	0.9	1.5	0.9	9	7	31	18	64	76	1.8	74	2.7	1.9
105	Czechoslovakia	3.9	1.1	0.5	0.2	10	12	17	14	70	71	2.0	77	1.9	1.6
106	Belgium	1.9	0.6	0.3	0.0	12	12	17	12	70	75	1.6	97	0.5	0.2
107	Greece	2.2	0.6	0.7	0.4	8	10	19	11	69	76	1.6	62	2.5	1.2
108	Israel	1.5	0.5	2.8	1.7	6	7	27	22	69	76	3.0	91	3.5	2.1
109	New Zealand	0.8	0.3	1.3	0.9	9	9	26	17	71	75	2.0	84	1.5	0.9
110	USA	56.6	18.3	1.0	0.9	9	9	23	15	70	76	1.8	75	1.2	1.1
111	Singapore	0.7	0.2	1.6	1.2	8	5	38	18	65	74	1.8	100	1.6	1.2
112	Ireland	1.1	0.3	1.2	0.9	12	9	22	18	70	74	2.4	57	2.2	1.2
113	Italy	10.7	2.8	0.6	0.1	10	10	18	10	69	76	1.3	69	1.0	0.5
114	Austria	1.4	0.4	0.3	0.0	13	12	18	11	69	75	1.4	58	0.1	0.7
115	Denmark	1.0	0.3	0.5	0.0	9	11	17	11	72	76	1.5	87	1.1	0.4
116	Germany, Fed.	9.9	3.2	0.3	0.0	11	12	17	11	70	75	1.4	87	0.8	0.3
117	Norway	0.9	0.3	0.6	0.3	9	11	18	12	73	77	1.7	75	5.0	0.9
118	Spain	8.7	2.4	1.0	0.4	9	10	21	12	69	77	1.5	78	2.4	1.2
119	United Kingdom	11.6	3.8	0.2	0.2	12	12	17	14	71	76	1.8	89	0.5	0.2
120	Australia	4.0	1.2	1.8	1.4	9	8	22	15	71	76	1.8	85	0.2	1.4
121	Canada	5.9	1.8	1.3	1.0	8	8	26	14	71	77	1.6	77	1.5	1.2
122	France	12.2	3.8	0.7	0.4	12	10	18	14	70	76	1.8	74	2.7	0.5
123	Germany, Dem.	3.4	1.1	-0.2	-0.3	13	13	17	13	70	74	1.7	77	0.1	-0.1
124	Switzerland	1.2	0.4	0.5	0.5	10	10	18	12	71	77	1.5	60	1.2	0.9
125	Hong Kong	1.3	0.4	2.1	1.5	7	6	35	12	66	77	1.2	94	2.3	1.8
126	Netherlands	3.0	0.9	0.9	0.5	8	9	21	13	73	77	1.6	89	1.5	0.6
127	Finland	1.0	0.3	0.3	0.4	9	11	19	12	68	75	1.6	60	2.5	0.4
128	Sweden	1.6	0.5	0.5	0.2	10	12	15	13	73	77	2.0	84	1.0	0.3
129	Japan	25.3	7.0	1.2	0.6	8	7	18	11	68	79	1.7	77	2.1	0.7

TABLE 6: ECONOMIC INDICATORS

		GNP per capita (US $) 1988	GNP per capita average annual growth rate (%)		Rate of inflation (%) 1980-88	% of population below absolute poverty level 1980-88		% of central government expenditure allocated to (1986-88)			ODA inflow in millions US $ 1988	ODA inflow as a % of recipient GNP 1988	Debt service as a % of exports of goods and services	
			1965-80	1980-88		urban	rural	health	education	defence			1970	1988
	Very High U5MR countries (over 140) Median	**295**	**0.8**	**-1.4**	**8**	**40**	**63**	**4**	**11**	**9**	**286**	**13**	**4**	**17**
1	Mozambique	100	. .	-7.5	34	. .	. .	. .	. .	. .	882	57	. .	8
2	Afghanistan	280[x]	0.6	. .	. .	18[x]	36[x]	. .	. .	. .	72	. .	. .	. .
3	Angola	1130[x]	. .	. .	. .	. .	. .	. .	. .	. .	157	. .	. .	. .
4	Mali	230	2.1[x]	0.4	4	27[x]	48[x]	2	9	8	427	24	1	11
5	Sierra Leone	240	0.7	-2.1	50	. .	65	6	13	3	102	11	11	6
6	Malawi	170	3.2	-0.6	13	25	85	7	11	7	335	25	8	18
7	Guinea	430	1.3	. .	. .	. .	. .	. .	. .	. .	262	11	. .	22
8	Burkina Faso	210	1.7	2.4	3	. .	. .	6	19	17	297	15	7	7
9	Ethiopia	120	0.4	-1.4	2	60	65	. .	. .	. .	912	16	11	37
10	Niger	300	-2.5	-4.2	4	. .	35	. .	. .	. .	371	17	4	21
11	Central African Rep.	380	0.8	-0.7	7	. .	91	. .	. .	. .	197	18	5	6
12	Chad	160	-1.9	. .	3	30[x]	56[x]	. .	. .	. .	264	31	4	3
13	Somalia	170	-0.1	-2.2	38	40	70	36[*]	2[*]	1[*]	447	46	2	5
14	Mauritania	480	-0.1	-1.3	9	. .	. .	. .	. .	. .	184	20	3	22
15	Liberia	450[x]	0.5	-5.2	. .	. .	23	7	16	9	64	. .	8	. .
16	Rwanda	320	1.6	-1.5	4	30	90	. .	. .	. .	247	12	1	10
17	Cambodia	. .	. .	. .	. .	. .	. .	. .	. .	. .	18	. .	. .	. .
18	Burundi	240	2.4	0.1	4	55[x]	85[x]	. .	. .	. .	183	15	2	25
19	Bhutan	180	. .	. .	9	. .	. .	. .	. .	. .	41	. .	. .	. .
20	Nepal	180	0.0	1.9	9	55	61	4	11	6	399	13	3	9
21	Yemen	600	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
22	Senegal	650	-0.5	0.3	8	. .	. .	. .	. .	. .	566	13	3	17
23	Bangladesh	170	-0.3	0.8	11	86[x]	86[x]	10	11	10	1590	9	. .	14
24	Madagascar	190	-0.4	-3.4	17	50	50	. .	. .	. .	304	15	4	39
25	Sudan	480	0.8	-4.2	34	. .	85[x]	. .	. .	. .	923	11	11	7
26	Tanzania	160	0.8	-1.3	26	. .	. .	6	8	16	975	26	5	17
27	Namibia	. .	. .	. .	. .	. .	. .	. .	. .	. .	21	. .	. .	. .
28	Nigeria	290	4.2	-4.3	12	. .	. .	1	3	3	119	. .	4	24
29	Gabon	2970	5.6	-3.1	1	. .	. .	. .	. .	. .	106	3	6	6
30	Uganda	280	-2.2	-2.5	101	. .	. .	2	15	26	353	8	3	14
31	Bolivia	570	1.7	-4.3	483	. .	85[x]	1	12	6	392	10	11	33
32	Pakistan	350	1.8	3.0	7	32	29	1	3	30	1439	4	24	17
33	Laos	180	. .	. .	. .	. .	. .	. .	. .	. .	77	11	. .	129
34	Benin	390	-0.3	-1.7	8	. .	65	. .	. .	. .	161	11	2	4
35	Cameroon	1010	2.4	3.0	7	15[x]	40[x]	4	13	8	286	3	3	12
36	Togo	370	1.7	-2.8	6	42	. .	4	13	8	199	16	3	18
37	India	340	1.5	3.3	7	28[*]	40[*]	2	3	19	2099	1	22	19
38	Ghana	400	-0.8	-1.4	46	59[*]	37[*]	9	26	3	474	8	6	20
	High U5MR countries (71-140) Median	**830**	**2.8**	**-1.1**	**12**	**29**	**55**	**6**	**16**	**10**	**251**	**5**	**7**	**20**
39	Côte d'Ivoire	770	2.8	-3.7	4	30	26	4	21	4	439	5	7	. .
40	Haiti	380	0.9	-2.1	8	65	80	. .	. .	. .	147	7	59	6
41	Lesotho	420	6.8	-0.7	12	50	55	7	16	10	108	16	5	5
42	Zaire	170	-1.3	-2.1	56	. .	80	. .	. .	. .	580	10	4	7
43	Zambia	290	-1.2	-4.9	34	25	. .	5	8	. .	477	22	6	14
44	Peru	1300	0.8	-1.2	119	49	. .	. .	. .	. .	272	1	12	8
45	Libyan Arab Jamahiriya	5420	0.0	-9.9	. .	. .	. .	. .	. .	. .	5	. .	. .	. .
46	Morocco	830	2.7	0.8	8	28	45	3	17	15	481	3	9	20
47	Congo	930	2.7	1.1	1	. .	. .	. .	. .	. .	88	5	12	29
48	Kenya	370	3.1	-0.2	10	10	55	7	23	9	808	10	6	19
49	Honduras	860	1.1	-1.7	5	14[x]	55[x]	. .	. .	. .	323	8	3	25
50	Algeria	2360	4.2	0.0	4	20[x]	. .	. .	. .	. .	137	. .	4	71
51	Indonesia	440	5.2	1.7	9	26	44	2	10	8	1626	2	7	34
52	Guatemala	900	3.0	-3.1	13	66[x]	74[x]	. .	. .	. .	232	3	7	27
53	Saudi Arabia	6200	4.0[x]	-5.9	-4	. .	. .	. .	. .	. .	19	. .	. .	. .
54	Egypt	660	2.8	2.8	11	21	25	3	12	20	1537	5	38	10
55	Nicaragua	830[x]	-0.7	-4.7	87	21	19	. .	. .	. .	209	. .	11	. .
56	Myanmar	220[x]	1.6	. .	3	40[x]	40[x]	8	12	19	451	4	12	22
57	South Africa	2290	3.2	-1.0	14	. .	. .	. .	. .	. .	. .	. .	. .	. .
58	El Salvador	940	1.5	-1.8	17	20	32	7	17	26	419	9	4	17
59	Turkey	1280	3.6	3.0	39	. .	. .	2	13	10	286	. .	22	31
60	Zimbabwe	650	1.7	-1.0	12	. .	. .	8	22	16	270	4	2	25
61	Iraq	2340[x]	. .	. .	30[x]	. .	. .	. .	. .	. .	9	. .	. .	. .
62	Botswana	1010	9.9	6.7	10	40	55	6	18	8	150	12	1	4
63	Mongolia	780[x]	. .	. .	. .	. .	. .	. .	. .	. .	3	. .	. .	. .

Note: nations are listed in descending order of tneir 1989 under five mortality rates (see table 1).

		GNP per capita (US $) 1988	GNP per capita average annual growth rate (%)		Rate of inflation (%) 1980-88	% of population below absolute poverty level 1980-88		% of central government expenditure allocated to (1986-88)			ODA inflow in millions US $ 1988	ODA inflow as a % of recipient GNP 1988	Debt service as a % of exports of goods and services	
			1965-80	1980-88		urban	rural	health	education	defence			1970	1988
64	Brazil	2160	6.3	1.2	189	..	..	6	3	3	210	..	13	36
65	Ecuador	1120	5.4	-1.1	31	40	65	7	25	12	136	1	9	21
66	Viet Nam	240[x]	..	..	..	..	..	..	..	..	150	..	..	..
67	Papua New Guinea	810	..	-0.1	5	10	75	10	16	5	377	13	1	16
68	Dominican Rep.	720	3.8	-1.6	17	45	43	12	13	8	118	3	4	11
69	Philippines	630	3.2	-2.4	16	50[*]	64[*]	6	18	9	854	2	8	25
	Middle U5MR countries (21-70) Median	**1725**	**3.7**	**0.0**	**12**	**19**	**30**	**6**	**13**	**11**	**75**	**1**	**11**	**18**
70	Tunisia	1230	4.7	0.6	8	20	15	6	15	6	326	3	20	22
71	Iran, Islamic Rep. of	3530[x]	2.9	..	..	..	..	6	20	14	67	..	..	..
72	Syria	1140	5.1	-3.1	13	..	..	1	9	39	205	1	11	19
73	Paraguay	1180	4.1	-2.1	22	19	50	3	12	12	75	2	12	25
74	Lebanon	2150[x]	..	..	..	..	..	..	..	..	141	..	..	..
75	Jordan	1500	5.8[x]	-1.4	2	14	17	4	14	30	431	10	4	24
76	Oman	5000	9.0	6.9	-7	..	..	5	11	38	1	..	..	..
77	Mexico	1760	3.6	-1.4	74	..	..	1	7	1	173	..	24	30
78	Colombia	1180	3.7	1.2	24	32[*]	70[*]	..	..	..	61	..	12	38
79	Venezuela	3250	2.3	-2.4	13	..	..	10	20	6	18	..	3	26
80	China	330	4.1	9.2	5	..	10[*]	..	..	..	1973	1	..	7
81	Argentina	2520	1.7	-1.6	291	..	..	2	6	7	152	..	22	33
82	Korea, Dem.	970[x]	..	..	..	..	..	..	..	..	10	..	..	..
83	Sri Lanka	420	2.8	2.8	11	..	..	4	8	7	592	8	11	14
84	Thailand	1000	4.4	3.8	3	15	34	6	19	19	557	1	3	11
85	USSR	4550[x]	..	..	..	..	..	..	..	..	..	..	..	..
86	Romania	2560[x]	..	..	..	..	..	1	2	5	..	..	..	24
87	Panama	2120	2.8	0.1	3	21	30	16	16	..	22	1	8	..
88	United Arab Emirates	15770	..	-9.0	..	..	..	6	10	45	-12	..	..	..
89	Korea, Rep.	3600	7.3	7.7	5	18	11	2	19	27	7	..	20	9
90	Albania	790[x]	..	..	..	..	..	..	..	..	..	..	..	..
91	Malaysia	1940	4.7	1.3	1	13	38	..	..	..	103	..	4	18
92	Mauritius	1800	3.7	5.1	8	12	12	8	13	1	59	3	3	10
93	Chile	1510	0.0	-0.1	21	..	..	6	13	11	44	..	19	15
94	Yugoslavia	2520	5.2	-0.1	67	..	..	..	..	55	41	..	10	8
95	Uruguay	2470	2.5	-1.4	57	22[*]	..	5	7	10	41	1	22	27
96	Costa Rica	1690	3.3	0.2	27	..	..	19	16	2	188	4	10	17
97	Jamaica	1070	-0.1	-2.1	19	..	80	7[*]	11[*]	8[*]	193	7	3	12
	Low U5MR (20 and under) Median	**12575**	**3.3**	**1.8**	**6**	**..**	**..**	**11**	**9**	**7**	**..**	**..**	**..**	**..**
98	Kuwait	13400	0.6[x]	-2.5	-4	..	..	8	14	14	6	..	..	..
99	Poland	1860	..	1.7	31	..	..	..	..	..	..	..	..	10
100	Trinidad and Tobago	3350	3.1	-7.3	5	..	39	..	..	..	8	..	5	9
101	Bulgaria	4150[x]	..	..	..	..	..	..	..	..	..	..	..	..
102	Hungary	2460	5.1	1.8	6	..	..	2	2	5	..	..	..	23
103	Portugal	3650	4.6	1.9	20	..	..	..	..	..	106	..	7	24
104	Cuba	1170[x]	..	..	..	..	..	..	..	..	20	..	..	..
105	Czechoslovakia	5820[x]	..	..	..	..	..	..	..	..	..	..	..	..
106	Belgium	14490	3.6	1.4	5	..	..	2	13	5	..	..	..	..
107	Greece	4800	4.8	0.1	19	..	..	..	..	..	34	..	9	26
108	Israel	8650	3.7	1.5	137	..	..	4	10	27	1241	3	3	..
109	New Zealand	10000	1.7	0.6	11	..	..	12	11	5	..	..	..	..
110	USA	19840	1.8	2.1	4	..	..	13	2	25	..	..	..	..
111	Singapore	9070	8.3	5.8	1	..	..	4	18	19	22	..	1	..
112	Ireland	7750	2.8	0.0	8	..	..	13	11	3	..	..	..	..
113	Italy	13330	3.2	1.7	11	..	..	10	8	3	..	..	..	..
114	Austria	15470	4.0	1.7	4	..	..	13	9	3	..	..	..	..
115	Denmark	18450	2.2	2.3	6	..	..	1	9	5	..	..	..	..
116	Germany, Fed.	18480	3.0	2.0	3	..	..	18	1	9	..	..	..	..
117	Norway	19990	3.6	3.8	6	..	..	11	9	8	..	..	..	..
118	Spain	7740	4.1	2.0	10	..	..	13	6	6	..	..	..	..
119	United Kingdom	12810	2.0	2.8	6	..	..	13	2	13	..	..	..	..
120	Australia	12340	2.2	1.7	8	..	..	10	7	9	..	..	..	..
121	Canada	16960	3.3	2.3	5	..	..	6	3	8	..	..	..	..
122	France	16090	3.7	1.2	7	..	..	21	8	6	..	..	..	..
123	Germany, Dem.	7180[x]	..	..	..	..	..	..	..	..	..	..	..	..
124	Switzerland	27500	1.5	1.6	4	..	..	13	3	10	..	..	..	..
125	Hong Kong	9220	6.2	5.7	7	..	..	..	..	..	18	..	..	..
126	Netherlands	14520	2.7	1.1	2	..	..	11	12	5	..	..	..	..
127	Finland	18590	3.6	2.7	7	..	..	11	14	5	..	..	..	..
128	Sweden	19300	2.0	1.9	8	..	..	1	9	7	..	..	..	..
129	Japan	21020	5.1	3.4	1	..	..	..	..	..	..	..	..	..

TABLE 7: WOMEN

		Life expectancy females as a percentage of males 1989	Adult literacy rate females as a percentage of males 1985	Enrolment ratios females as a percentage of males 1986-88		Contraceptive prevalence (%) 1980-88	Pregnant women immunized against Tetanus 1988-89	% of births attended by trained health personnel 1983-88	Maternal mortality rate 1980-88
				Primary school	Secondary-school				
	Very high U5MR countries (over 140) Median	**106.1**	**42**	**69**	**50**	**6**	**32**	**28**	**550**
1	Mozambique	106.5	41	78	57	4	43	28	300
2	Afghanistan	102.4	24	52	50	2^{x}	20	8	690^{x}
3	Angola	106.8	46	..	..	1	23	15	..
4	Mali	107.0	48	59	44	3	38	27	..
5	Sierra Leone	107.5	29	71	48	..	79	25	450
6	Malawi	102.1	..	81	60	7	72	45	100^{x}
7	Guinea	102.3	31	44	31	1^{x}	6	25	..
8	Burkina Faso	108.7	26	59	50	1	51	30	810
9	Ethiopia	106.8	..	61	67	2	24	14	..
10	Niger	106.8	34	54	..	1^{x}	18	47	420
11	Central African Rep.	110.6	42	62	35	..	40	66	600
12	Chad	106.7	38	40	20	1^{x}	42	24^{x}	960^{*}
13	Somalia	106.8	33	..	..	..	21	2	1100
14	Mauritania	106.7	40	69	39	1	21	20	..
15	Liberia	101.9	49	61	..	6	20	87	..
16	Rwanda	106.3	54	96	71	10	87	22	210^{x}
17	Cambodia	104.1	41	..	44	..	22	47^{*}	..
18	Burundi	106.4	60	74	50	7	80	21	..
19	Bhutan	98.0	42	65	29	..	42	7	1710
20	Nepal	98.1	32	45	31	14	26	6	830
21	Yemen	100.0	45	30	17	..	8	..	..
22	Senegal	104.3	42	69	53	5	37	50^{x}	600
23	Bangladesh	98.1	42	84	46	25	57	5	600
24	Madagascar	105.7	79	95	83	..	12	62	240
25	Sudan	106.1	26	69	74	9	32^{x}	20	660
26	Tanzania	105.8	95^{y}	99	60	1^{x}	48	60	340^{x}
27	Namibia	103.6	..	..	..	..	..	..	..
28	Nigeria	108.2	56	..	..	6	21	40^{x}	800
29	Gabon	105.9	61	..	..	..	54	92^{*}	..
30	Uganda	106.0	51	83	56	5	14	45	300
31	Bolivia	107.7	80	88	88	30	20	36^{*}	480
32	Pakistan	100.0	42	55	42	8	31	24^{*}	500
33	Laos	106.3	..	83	70	..	4	..	..
34	Benin	106.7	46	51	39	9	60	45	..
35	Cameroon	105.8	59	84	63	2^{x}	32	..	300^{x}
36	Togo	107.7	49	63	33	12	63	15	..
37	India	101.7	50	72	54	34	69	33	340
38	Ghana	105.7	66	81	65	13	19	40	1000
	High U5MR countries (71-140) Median	**106.5**	**73**	**95**	**88**	**34**	**41**	**46**	**140**
39	Côte d'Ivoire	107.8	54	..	46	3	34	20	..
40	Haiti	105.6	78	87	89	7	5	40	230
41	Lesotho	117.3	..	125	144	5^{x}	..	40	..
42	Zaire	105.9	67	81	44	1^{x}	24	..	..
43	Zambia	103.8	77	90	..	1^{x}	45	..	150
44	Peru	106.7	83	96	90	46	12	44	88
45	Libyan Arab Jamahiriya	105.0	57	..	..	..	9	76^{x}	80^{x}
46	Morocco	105.0	56	66	70	36	45	29^{x}	300^{x}
47	Congo	109.8	58	..	..	..	47	..	900^{*}
48	Kenya	107.0	69	95	70	27	62	28	170^{x}
49	Honduras	108.1	92	104	..	35	16	50	50
50	Algeria	103.1	56	83	75	7^{x}	..	15	130
51	Indonesia	105.0	80	96	..	48	41	31	450
52	Guatemala	106.6	73	85	..	23	18	34	110
53	Saudi Arabia	106.5	62	83	67	..	50	74	..
54	Egypt	103.4	50	79	73	38	58	47	320
55	Nicaragua	104.8	..	111	200	27	25	41	47
56	Myanmar	106.8	78	..	..	5	42	57	140
57	South Africa	110.3	..	..	..	48	..	..	83^{x}
58	El Salvador	111.7	89	105	111	47	19	35	70
59	Turkey	106.3	73	93	60	51	15	78^{*}	210
60	Zimbabwe	107.0	79	97	86	43	58	69	480^{x}
61	Iraq	103.2	64	87	63	..	56	50^{*}	..
62	Botswana	110.7	73	105	106	33	79	77	250
63	Mongolia	103.3	..	103	109	..	..	99	100

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		Life expectancy females as a percentage of males 1989	Adult literacy rate females as a percentage of males 1985	Enrolment ratios females as a percentage of males 1986-88		Contraceptive prevalence (%) 1980-88	Pregnant women immunized against Tetanus 1988-89	% of births attended by trained health personnel 1983-88	Maternal mortality rate 1980-88
				Primary-school	Secondary-school				
64	Brazil	107.9	96	. .	128	66	. .	95	120
65	Ecuador	106.3	94	98	104	44	5	27	190
66	Viet Nam	106.7	89	88	93	20	. .	. .	140
67	Papua New Guinea	101.9	53	85	56	4	50	34	900
68	Dominican Rep.	107.8	96	104	. .	50	24	57	74
69	Philippines	106.5	99	102	100	45	43	57	93
	Midddle U5MR countries (21-70) Median	**106.3**	**93**	**98**	**99**	**55**	**54**	**84**	**59**
70	Tunisia	101.5	69	85	74	50	32	68	310^{x}
71	Iran, Islamic Rep. of	98.5	61	86	68	23^{x}	56	82*	120
72	Syria	106.3	59	90	70	20^{x}	93	37^{x}	280
73	Paraguay	106.2	95	95	100	45	54	22	380
74	Lebanon	106.3	80	90	98	. .	. .	. .	. .
75	Jordan	104.6	72	101	98	26	26	83	. .
76	Oman	104.7	. .	89	63	. .	70	60	. .
77	Mexico	110.6	93	97	98	53	. .	94	82
78	Colombia	107.6	98	103	102	65	40	51	110
79	Venezuela	109.0	105	100	123	49^{x}	. .	82^{x}	59
80	China	105.9	69	89	74	74	. .	. .	44
81	Argentina	108.8	99	100	113	74	. .	. .	69
82	Korea, Dem.	109.0	. .	. .	. .	. .	. .	65	41
83	Sri Lanka	105.8	88	97	110	62	39	87	60
84	Thailand	106.3	92	. .	. .	66	70	40^{x}	50
85	USSR	113.6	. .	. .	. .	. .	. .	98	48
86	Romania	107.4	. .	. .	101	58^{x}	. .	100^{x}	150
87	Panama	105.7	99	95	113	58	27	89	57
88	United Arab Emirates	105.8	. .	102	120	. .	. .	96	. .
89	Korea, Rep.	109.0	93	100	95	70	. .	70^{x}	26
90	Albania	107.1	. .	99	89	. .	. .	. .	. .
91	Malaysia	105.9	78	100	100	51	54	82	59
92	Mauritius	107.5	. .	102	94	75	63	85	100
93	Chile	110.3	99	98	106	43^{x}	. .	98	47
94	Yugoslavia	108.7	88	99	96	55^{x}	. .	86^{x}	22
95	Uruguay	110.1	99	98	. .	. .	13	97	38
96	Costa Rica	105.5	100	97	108	70	90	96^{x}	36
97	Jamaica	105.6	100	102	108	52	50	89	110
	Low U5MR countries (20 and under) Median	**106.3**	**. .**	**100**	**104**	**73**	**. .**	**100**	**9**
98	Kuwait	105.6	84	97	92	. .	. .	99	6
99	Poland	111.8	. .	100	105	75^{x}	. .	100^{x}	11
100	Trinidad and Tobago	107.2	. .	101	106	53	60	98	54
101	Bulgaria	108.7	. .	98	101	76^{x}	. .	100	13
102	Hungary	110.4	. .	100	101	73	. .	99^{x}	26
103	Portugal	110.0	90	94	119	66^{x}	. .	87^{x}	12
104	Cuba	104.1	97	93	108	60	. .	. .	29*
105	Czechoslovakia	110.3	. .	101	181	95^{x}	. .	100	10
106	Belgium	108.3	. .	101	101	81^{x}	. .	100	9
107	Greece	105.4	89	100	90	. .	. .	97^{x}	9
108	Israel	105.4	. .	103	110	. .	. .	100^{x}	5
109	New Zealand	108.3	. .	99	102	70^{x}	. .	99	6
110	USA	109.7	. .	99	101	68	. .	99	8
111	Singapore	108.5	. .	96	104	74	90	100	5
112	Ireland	106.9	. .	100	111	. .	. .	. .	12
113	Italy	108.2	99	. .	. .	78^{x}	. .	100^{x}	10
114	Austria	109.9	. .	99	104	71^{x}	. .	. .	7
115	Denmark	108.2	. .	101	101	. .	. .	100^{x}	4
116	Germany, Fed.	108.3	. .	100	96	78	. .	100^{x}	11
117	Norway	108.1	. .	100	105	71^{x}	. .	100^{x}	2
118	Spain	108.1	95	100	110	59	. .	96	11
119	United Kingdom	106.8	. .	101	104	83	. .	100^{x}	9
120	Australia	109.6	. .	99	103	. .	. .	99^{x}	8
121	Canada	109.5	. .	98	100	73	. .	99	3
122	France	111.1	. .	99	108	79^{x}	. .	99^{x}	14
123	Germany, Dem.	108.5	. .	98	96	. .	. .	99^{x}	16
124	Switzerland	109.5	. .	. .	. .	71^{x}	. .	99^{x}	5
125	Hong Kong	106.7	. .	99	107	72	. .	92	5
126	Netherlands	108.1	. .	102	98	76^{x}	. .	100^{x}	5
127	Finland	111.3	. .	99	116	80^{x}	. .	100^{x}	6
128	Sweden	108.1	. .	. .	102	78	. .	100^{x}	5
129	Japan	107.9	. .	100	102	64	. .	100	16

TABLE 8: BASIC INDICATORS ON LESS POPULOUS COUNTRIES

		Under 5 mortality rate		Infant mortality rate		Total population (thousands)	Annual no. of births (thousands)	Annual no. of under 5 deaths (thousands)	GNP per capita (US $)	Life expectancy at birth (years)	Total adult literacy rate	% of age group enrolled in primary school Total	% of children immunized against measles
		1960	1989	1960	1989	1989	1989	1989	1988	1989	1985	1982-88	1988-89
1	Guinea Bissau	336	250	200	148	944	40.4	10.1	190	42	30	53	44
2	Gambia	375	241	213	140	837	39.5	9.5	200	44	20	61	81
3	Equatorial Guinea	316	210	188	124	345	15.2	3.2	410	47	45	108	50
4	Swaziland	226	170	152	115	761	35.5	6.0	810	56	68	105	85
5	Djibouti	. .	167	186	119	397	18.3	3.1	1210[x]	48	12[*]	46	84
6	Comoros	279	155	165	96	531	25.2	3.9	440	55	48[x]	80	85
7	Maldives	. .	. .	. .	87[x]	208	8.2[x]	. .	410	59[x]	93[y]	85[*]	88
8	Kiribati	. .	. .	. .	62[x]	65	2.2	. .	650	54[x]	96[*]	100[*]	63
9	Vanuatu	. .	. .	. .	56[x]	154	5.9	. .	840	63[x]	53[x]	87[*]	46
10	Guyana	126	73	100	54	794	20.8	1.5	420	64	95	79	69
11	Samoa	. .	. .	. .	50[x]	167	5.5	. .	640	65[x]	98[*]	91[*]	88
12	Belize	. .	. .	. .	50[x]	183	6.7[x]	. .	1500	67[x]	91	103[*]	68
13	Sao Tome and Principe	. .	. .	. .	49[x]	118	4.1	. .	490	65[x]	58[x]	. .	45
14	Solomon Islands	. .	. .	. .	43[x]	310	12.0[x]	. .	630	67[x]	15[*]	65[*]	92
15	Cape Verde	164	58	110	42	359	14.7	0.9	680	67	50	108	84
16	St. Christopher-Nevis	. .	. .	. .	40[x]	44	1.0[x]	. .	2630	68[x]	90[*]	100	90
17	Grenada	. .	. .	. .	34[x]	85	2.7[x]	. .	1720	69[x]	96[*]	88	89
18	Suriname	95	40	70	32	414	11.6	0.5	2460	69	93	125	73
19	Qatar	239	37	145	30	354	10.6	0.4	9930	69	76	117	73
20	British Virgin Islands	. .	. .	. .	29[x]	13	0.2	. .	8500[x]	. .	98[x]	. .	87
21	Fiji	98	32	71	26	751	20.0	0.6	1520	64	86	129	69
22	Bahamas	. .	. .	. .	26[x]	249	4.9[x]	. .	10700	70[x]	. .	85	78
23	Tonga	. .	. .	. .	26[x]	95	3.0	. .	830	66[x]	78[*]	100[*]	81
24	St. Vincent	. .	. .	. .	25[x]	114	2.7[x]	. .	1200	69[x]	82[*]	95	100
25	Turks & Caicos Islands	. .	. .	. .	25[x]	10	0.2[x]	. .	780[x]	. .	98[x]	. .	76
26	Marshall Islands	. .	. .	. .	23[x]	38	1.2	. .	. .	73[x]	76[y]	107[*]	25
27	Federal States of Micronesia	. .	. .	. .	23[x]	96	3.0	. .	. .	73[x]	63[y]	101[*]	84
28	Palau	. .	. .	. .	23[x]	17	0.5	. .	. .	73[x]	75[*]	98[*]	100[x]
29	Antigua	. .	. .	. .	22[x]	76	1.1[x]	. .	3690	73[x]	95[*]	100	95
30	Cook Islands	. .	. .	. .	22[x]	18	0.4[x]	. .	1550[x]	. .	75[*]	100	92
31	St. Lucia	. .	. .	. .	21[x]	148	3.2	. .	1540	71[x]	82[x]	110	91
32	Dominica	. .	. .	. .	18[x]	82	1.7[x]	. .	1680	74[x]	94[x]	100[*]	88
33	Seychelles	. .	. .	. .	18[x]	68	1.6	. .	3800	70[x]	88[*]	102[*]	89
34	Bahrain	208	19	130	15	498	13.8	0.3	6340	71	73	110	85
35	Brunei Darussalam	. .	. .	. .	12[x]	258	6.9[x]	. .	20760[x]	74[x]	. .	115	100
36	Barbados	90	15	74	11	254	4.0	0.1	6010	75	98[*]	110	85
37	Cyprus	36	14	30	12	694	12.6	0.2	6260	76	89[x]	104	74
38	Luxembourg	41	13	33	9	371	4.5	0.1	22400	75	. .	. .	71
39	Malta	42	10	37	8	350	4.9	0.0	5190	73	88	108	86
40	Montserrat	. .	. .	. .	8[x]	12	0.2[x]	. .	3330[x]	77[x]	97[x]	100[*]	89
41	Iceland	22	8	17	6	251	4.1	0.0	20190	78	. .	99	99

Note: nations are listed in descending order of their 1989 infant mortality rate where no under five mortality rate is available.

Measuring human development

An introduction to Table 9.

If development in the 1990s is to assume a more human face then there arises a corresponding need for a means of measuring human as well as economic progress. From UNICEF's point of view, in particular, there is a need for an agreed method of measuring the level of child well-being and its rate of change.

The under five mortality rate (U5MR) is used in Table 9 (next page) as the principle indicator of such progress.

U5MR has several advantages. First, it measures an end result of the development process rather than an 'input' such as school enrolment level, per capita calorie availability, or the number of doctors per thousand population - all of which are means to an end.

Second, the U5MR is known to be the result of a wide variety of inputs: the nutritional health and the health knowledge of mothers; the level of immunization and ORT use; the availability of maternal and child health services (including pre-natal care); income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment.

Third, U5MR is less susceptible than, say, per capita GNP to the fallacy of the average. This is because the natural scale does not allow the children of the rich to be one thousand times as likely to survive, even if the man-made scale does permit them to have one thousand times as much income. In other words, it is much more difficult for a wealthy minority to affect a nation's U5MR, and it therefore presents a more accurate, if far from perfect, picture of the health status of the majority of children (and of society as a whole).

For these reasons, the U5MR is chosen by UNICEF as its single most important indicator of the state of a nation's children. That is why the statistical annex lists the nations of the world not in ascending order of their per capita GNP but in descending order of their under five mortality rates.

Measuring the rate of progress

The speed of progress in reducing the U5MR can be measured by calculating its average annual reduction rate (AARR). Unlike the comparison of absolute changes, the AARR reflects the fact that the limits to U5MR are approached only with increasing difficulty. As lower levels of under five mortality are reached, for example, the same absolute reduction obviously represents a greater percentage of reduction. The AARR therefore shows a higher rate of progress for, say, a ten point reduction if that reduction happens at a lower level of under five mortality. (A fall in U5MR of 10 points from 100 to 90 represents a reduction of 10%, whereas the same 10-point fall from 20 to 10 represents a reduction of 50%).

When used in conjunction with GNP growth rates, the U5MR and its reduction rate can therefore give a picture of the progress being made by any country or region, and over any period of time, towards the satisfaction of some of the most essential of human needs.

As Table 9 shows, there is no fixed relationship between the annual reduction rate of the U5MR and the annual rate of growth in per capita GNP. Such comparisons help to throw the emphasis on to the policies, priorities, and other factors which determine the ratio between economic and social progress.

Finally, the table gives the total fertility rate for each country and its average annual rate of reduction. It will be seen that many of the nations which have achieved significant reductions in U5MR have also achieved significant reductions in fertility.

TABLE 9: THE RATE OF PROGRESS

		Under 5 mortality rate						GNP per capita average annual growth rate (%)		Total fertility rate				
					average annual rate of reduction (%)								average annual rate of reduction (%)	
		1960	1980	1989	1960-80	1980-89	required ** 1989-2000	1965-80	1980-88	1960	1980	1989	1960-80	1980-89
	Very high U5MR countries (over 140) Median	**299**	**228**	**193**	**1.3**	**1.8**	**9.2**	**0.8**	**-1.4**	**6.7**	**6.5**	**6.6**	**0.0**	**0.0**
1	Mozambique	331	268	297	1.1	-1.1	13.1	. .	-7.5	6.3	6.5	6.4	-0.2	0.2
2	Afghanistan	381	320	296	0.9	0.9	13.1	0.6	. .	6.9	7.1	6.9	-0.1	0.3
3	Angola	345	260	292	1.4	-1.3	13.0	. .	. .	6.4	6.4	6.4	0.0	0.0
4	Mali	369	325	287	0.6	1.4	12.8	2.1ᵃ	0.4	7.1	6.7	7.1	0.3	-0.6
5	Sierra Leone	385	300	261	1.3	1.6	12.0	0.7	-2.1	6.2	6.5	6.5	-0.2	0.0
6	Malawi	366	299	258	1.0	1.6	11.9	3.2	-0.6	6.9	7.0	7.6	-0.1	-0.9
7	Guinea	336	275	241	1.0	1.5	11.2	1.3	. .	7.0	6.2	7.0	0.6	-1.4
8	Burkina Faso	363	266	232	1.6	1.5	10.9	1.7	2.4	6.7	6.5	6.5	0.2	0.0
9	Ethiopia	294	260	226	0.6	1.6	10.7	0.4	-1.4	6.7	6.5	6.9	0.2	-0.7
10	Niger	321	259	225	1.1	1.6	10.6	-2.5	-4.2	7.1	7.1	7.1	0.0	0.0
11	Central African Rep.	308	244	219	1.2	1.2	10.4	0.8	-0.7	5.6	5.9	6.2	-0.3	-0.6
12	Chad	325	254	220	1.2	1.6	10.4	-1.9	. .	6.0	5.9	5.9	0.1	0.0
13	Somalia	294	247	218	0.9	1.4	10.3	-0.1	-2.2	6.6	6.6	6.6	0.0	0.0
14	Mauritania	321	249	217	1.3	1.5	10.3	-0.1	-1.3	6.5	6.5	6.5	0.0	0.0
15	Liberia	310	245	209	1.2	1.8	10.0	0.5	-5.2	6.6	6.5	6.8	0.1	-0.5
16	Rwanda	248	231	201	0.4	1.6	9.6	1.6	-1.5	7.5	8.5	8.2	-0.6	0.4
17	Cambodia	218	330	200	-2.1	5.6	9.5	. .	. .	6.3	4.6	4.6	1.6	0.0
18	Burundi	260	225	196	0.7	1.5	9.3	2.4	0.1	6.8	6.4	6.8	0.3	-0.7
19	Bhutan	298	222	193	1.5	1.6	9.2	. .	. .	6.0	5.6	5.5	0.3	0.2
20	Nepal	298	222	193	1.5	1.6	9.2	0.0	1.9	5.8	6.4	5.8	-0.5	1.1
21	Yemen	378	235	192	2.4	2.3	9.2	. .	. .	7.5	7.7	7.7	-0.1	0.0
22	Senegal	299	232	189	1.3	2.3	9.0	-0.5	0.3	7.0	6.5	6.4	0.4	0.2
23	Bangladesh	262	212	184	1.1	1.6	8.8	-0.3	0.8	6.7	6.4	5.3	0.2	2.1
24	Madagascar	364	216	179	2.6	2.1	8.5	-0.4	-3.4	6.6	6.6	6.6	0.0	0.0
25	Sudan	292	210	175	1.7	2.0	8.3	0.8	-4.2	6.7	6.6	6.4	0.1	0.3
26	Tanzania	249	202	173	1.1	1.7	8.2	0.8	-1.3	6.8	7.1	7.1	-0.2	0.0
27	Namibia	263	202	171	1.3	1.9	8.1	. .	. .	6.0	6.1	6.1	-0.1	0.0
28	Nigeria	317	198	170	2.4	1.7	8.1	4.2	-4.3	6.8	7.1	6.9	-0.2	0.3
29	Gabon	287	194	167	2.0	1.7	7.9	5.6	-3.1	4.1	4.4	5.1	-0.4	-1.6
30	Uganda	223	187	167	0.9	1.3	7.9	-2.2	-2.5	6.9	6.9	7.3	0.0	-0.6
31	Bolivia	282	207	165	1.6	2.5	7.8	1.7	-4.3	6.7	6.3	6.0	0.3	0.5
32	Pakistan	276	193	162	1.8	2.0	7.6	1.8	3.0	6.9	7.0	6.4	-0.1	1.0
33	Lao People's Dem. Rep.	233	190	156	1.0	2.2	7.3	. .	. .	6.2	6.2	6.7	0.0	-0.9
34	Benin	310	176	150	2.8	1.8	6.9	-0.3	-1.7	6.9	7.0	7.1	-0.1	-0.2
35	Cameroon	276	176	150	2.3	1.8	7.0	2.4	3.0	5.8	6.3	7.0	-0.4	-1.2
36	Togo	305	184	150	2.5	2.3	6.9	1.7	-2.8	6.6	6.1	6.6	0.4	-0.9
37	India	282	181	146	2.2	2.4	6.7	1.5	3.3	5.9	4.8	4.2	1.0	1.5
38	Ghana	224	166	143	1.5	1.7	6.5	-0.8	-1.4	6.9	6.5	6.4	0.3	0.2
	High U5MR countries (71-140) Median	**230**	**132**	**94**	**2.5**	**2.8**	**4.0**	**2.8**	**-1.1**	**6.9**	**5.8**	**5.2**	**0.8**	**1.5**
39	Côte d'Ivoire	264	167	139	2.3	2.0	6.2	2.8	-3.7	7.2	7.4	7.4	-0.1	0.0
40	Haiti	270	163	133	2.5	2.3	5.8	0.9	-2.1	6.3	5.2	4.9	1.0	0.7
41	Lesotho	208	162	133	1.3	2.2	5.8	6.8	-0.7	5.8	5.8	5.8	0.0	0.0
42	Zaire	269	163	132	2.5	2.3	5.8	-1.3	-2.1	6.0	6.1	6.1	-0.1	0.0
43	Zambia	228	146	125	2.2	1.7	5.3	-1.2	-4.9	6.6	7.2	7.2	-0.4	0.0
44	Peru	233	144	119	2.4	2.1	4.8	0.8	-1.2	6.9	5.2	3.8	1.4	3.5
45	Libyan Arab Jamahiriya	269	150	116	2.9	2.9	4.6	0.0	-9.9	7.1	7.3	6.8	-0.1	0.8
46	Morocco	265	153	116	2.8	3.1	4.6	2.7	0.8	7.2	5.7	4.6	1.2	2.4
47	Congo	241	132	112	3.0	1.8	4.3	2.7	1.1	5.9	6.0	6.3	-0.1	-0.5
48	Kenya	208	133	111	2.2	2.0	4.2	3.1	-0.2	8.0	8.1	6.7	-0.1	2.1
49	Honduras	232	141	103	2.5	3.5	4.0	1.1	-1.7	7.3	6.4	5.4	0.7	1.9
50	Algeria	270	147	102	3.0	4.1	4.1	4.2	0.0	7.3	6.9	5.2	0.3	3.1
51	Indonesia	225	139	100	2.4	3.7	4.0	5.2	1.7	5.5	4.4	3.3	1.1	3.2
52	Guatemala	230	130	98	2.9	3.1	4.0	3.0	-3.1	6.9	6.3	5.7	0.5	1.1
53	Saudi Arabia	292	131	95	4.0	3.6	4.0	4.0ᵃ	-5.9	7.2	7.3	7.1	-0.1	0.3
54	Egypt	301	172	94	2.8	6.7	4.3	2.8	2.8	7.0	5.3	4.4	1.4	2.1
55	Nicaragua	209	133	92	2.3	4.1	4.1	-0.7	-4.7	7.3	6.1	5.4	0.9	1.4
56	Myanmar	230	118	91	3.3	2.9	3.9	1.6	. .	6.0	4.8	3.8	1.1	2.6
57	South Africa	192	120	91	2.4	3.1	4.0	3.2	-1.0	6.5	4.9	4.4	1.4	1.2
58	El Salvador	207	122	90	2.6	3.4	4.0	1.5	-1.8	6.8	5.5	4.8	1.1	1.5
59	Turkey	258	139	90	3.1	4.8	4.1	3.6	3.0	6.3	4.1	3.6	2.2	1.5
60	Zimbabwe	181	116	90	2.2	2.8	3.9	1.7	-1.0	7.5	6.4	5.7	0.8	1.3
61	Iraq	222	110	89	3.5	2.4	3.9	. .	. .	7.2	6.8	6.3	0.3	0.9
62	Botswana	173	110	88	2.3	2.5	3.9	9.9	6.7	6.8	6.6	7.1	0.2	-0.8
63	Mongolia	185	112	87	2.5	2.8	4.0	. .	. .	6.0	5.5	4.9	0.4	1.3

*** The average annual reduction rate required to achieve an under five mortality rate in all countries of 70 per 1,000 live births or of two-thirds the 1990 rate, whichever is less.*

Note: nations are listed in descending order of their 1989 under five mortality rates (see table 1).

		Under 5 mortality rate						GNP per capita average annual growth rate (%)		Total fertility rate				
					average annual rate of reduction (%)								average annual rate of reduction (%)	
		1960	1980	1989	1960-80	1980-89	required** 1989-2000	1965-80	1980-88	1960	1980	1989	1960-80	1980-89
64	Brazil	159	103	85	2.2	2.1	3.9	6.3	1.2	6.2	4.0	3.4	2.2	1.8
65	Ecuador	184	107	85	2.7	2.6	3.9	5.4	-1.1	6.9	5.2	4.1	1.4	2.6
66	Viet Nam	232	116	85	3.5	3.5	4.0	. .	. .	6.1	5.2	3.9	0.8	3.2
67	Papua New Guinea	248	112	83	4.0	3.3	4.0	. .	-0.1	6.3	6.0	5.2	0.2	1.6
68	Dominican Rep.	199	103	80	3.3	2.8	3.9	3.8	-1.6	7.4	4.5	3.6	2.5	2.5
69	Philippines	134	87	71	2.2	2.3	3.9	3.2	-2.4	6.9	4.9	4.2	1.7	1.7
	Middle U5MR countries (21-70) Median	**121**	**40**	**36**	**4.5**	**3.7**	**4.0**	**3.7**	**0.0**	**6.1**	**3.9**	**3.0**	**2.0**	**1.6**
70	Tunisia	254	103	66	4.5	5.0	4.2	4.7	0.6	7.1	5.3	3.9	1.5	3.4
71	Iran, Islamic Rep. of	254	114	64	4.0	6.4	4.3	2.9	. .	7.2	5.8	5.1	1.1	1.4
72	Syrian Arab Rep.	217	88	62	4.5	3.9	4.0	5.1	-3.1	7.3	7.3	6.6	0.0	1.1
73	Paraguay	134	70	61	3.3	1.5	3.8	4.1	-2.1	6.8	4.9	4.5	1.6	1.0
74	Lebanon	91	62	57	1.9	0.9	3.8	. .	. .	6.3	4.0	3.8	2.3	0.6
75	Jordan	217	81	55	4.9	4.3	4.1	5.8[x]	-1.4	7.7	7.3	6.0	0.3	2.2
76	Oman	378	110	53	6.2	8.1	4.5	9.0	6.9	7.2	7.2	7.2	0.0	0.0
77	Mexico	140	68	51	3.6	3.2	4.0	3.6	-1.4	6.8	4.5	3.4	2.1	3.1
78	Colombia	157	65	50	4.4	2.9	4.0	3.7	1.2	6.8	4.1	3.0	2.5	3.5
79	Venezuela	114	50	44	4.1	1.4	3.8	2.3	-2.4	6.5	4.3	3.7	2.1	1.7
80	China	203	56	43	6.4	2.9	4.0	4.1	9.2	5.7	2.6	2.5	3.9	0.4
81	Argentina	75	47	36	2.3	3.0	4.0	1.7	-1.6	3.1	3.3	2.9	-0.3	1.4
82	Korea, Dem. Rep. of	120	44	36	5.0	2.2	3.9	. .	. .	5.7	4.5	2.4	1.4	6.5
83	Sri Lanka	114	53	36	3.8	4.3	4.1	2.8	2.8	5.3	3.5	2.5	2.1	3.7
84	Thailand	149	60	35	4.6	6.0	4.2	4.4	3.8	6.4	3.9	2.3	2.5	5.9
85	USSR	53	37	35	1.8	0.6	3.7	. .	. .	2.7	2.3	2.4	0.8	-0.5
86	Romania	82	36	34	4.1	0.6	3.7	. .	. .	2.3	2.4	2.1	-0.2	1.5
87	Panama	105	43	33	4.5	2.9	4.0	2.8	0.1	5.9	3.8	3.0	2.2	2.6
88	United Arab Emirates	239	43	31	8.6	3.6	4.0	. .	-9.0	6.9	5.4	4.7	1.2	1.5
89	Korea, Rep. of	120	44	31	5.0	3.9	4.1	7.3	7.7	5.7	2.6	1.5	3.9	6.1
90	Albania	151	58	30	4.8	7.3	4.4	. .	. .	5.9	3.8	2.9	2.2	3.0
91	Malaysia	105	42	30	4.6	3.7	4.0	4.7	1.3	6.8	4.0	3.9	2.7	0.3
92	Mauritius	104	42	29	4.5	4.1	4.1	3.7	5.1	5.9	2.7	1.9	3.9	3.9
93	Chile	143	44	27	5.9	5.4	4.2	0.0	-0.1	5.3	2.8	2.7	3.2	0.4
94	Yugoslavia	113	37	27	5.6	3.5	4.0	5.2	-0.1	2.8	2.1	1.9	1.4	1.1
95	Uruguay	57	43	27	1.4	5.2	4.2	2.5	-1.4	2.9	2.8	2.4	0.2	1.7
96	Costa Rica	121	31	22	6.8	3.8	4.0	3.3	0.2	7.0	3.7	3.2	3.2	1.6
97	Jamaica	89	28	21	5.8	3.2	4.0	-0.1	-2.1	5.4	3.7	2.4	1.9	4.8
	Low U5MR countries (20 and under) Median	**36**	**15**	**11**	**4.7**	**4.1**	**4.1**	**3.3**	**1.8**	**2.8**	**1.9**	**1.7**	**2.1**	**0.7**
98	Kuwait	128	35	20	6.5	6.2	4.3	0.6[x]	-2.5	7.3	5.6	3.6	1.3	4.9
99	Poland	70	25	18	5.2	3.7	4.0	. .	1.7	3.0	2.3	2.2	1.3	0.5
100	Trinidad and Tobago	67	26	18	4.7	4.1	4.0	3.1	-7.3	5.2	3.0	2.9	2.8	0.4
101	Bulgaria	69	24	17	5.3	3.8	4.0	. .	. .	2.2	2.1	1.9	0.2	1.1
102	Hungary	57	26	17	3.9	4.7	4.1	5.1	1.8	2.0	2.0	1.7	0.0	1.8
103	Portugal	112	31	16	6.4	7.4	4.4	4.6	1.9	3.1	2.2	1.7	1.7	2.9
104	Cuba	87	25	14	6.2	6.4	4.3	. .	. .	4.2	2.0	1.8	3.7	1.2
105	Czechoslovakia	33	20	13	2.5	4.8	4.1	. .	. .	2.5	2.2	2.0	0.6	1.1
106	Belgium	35	14	12	4.6	1.7	3.8	3.6	1.4	2.6	1.7	1.6	2.1	0.7
107	Greece	64	23	12	5.1	7.2	4.3	4.8	0.1	2.2	2.1	1.6	0.2	3.0
108	Israel	39	19	12	3.6	5.1	4.1	3.7	1.5	3.9	3.3	3.0	0.8	1.1
109	New Zealand	26	16	12	2.4	3.2	4.0	1.7	0.6	3.9	2.1	2.0	3.1	0.5
110	USA	29	15	12	3.3	2.5	4.0	1.8	2.1	3.5	1.9	1.8	3.1	0.6
111	Singapore	49	16	12	5.6	3.2	4.0	8.3	5.8	5.5	1.8	1.8	5.6	0.0
112	Ireland	36	14	11	4.7	2.7	3.9	2.8	0.0	3.8	3.2	2.4	0.9	3.2
113	Italy	50	18	11	5.1	5.5	4.3	3.2	1.7	2.5	1.7	1.3	1.9	3.0
114	Austria	43	17	10	4.6	5.9	4.3	4.0	1.7	2.7	1.6	1.4	2.6	1.5
115	Denmark	25	10	10	4.6	0.0	3.7	2.2	2.3	2.6	1.6	1.5	2.4	0.7
116	Germany, Fed. Rep. of	39	16	10	4.5	5.2	4.2	3.0	2.0	2.4	1.4	1.4	2.7	0.0
117	Norway	22	10	10	3.9	0.0	3.6	3.6	3.8	2.9	1.7	1.7	2.7	0.0
118	Spain	57	17	10	6.1	5.9	4.3	4.1	2.0	2.8	2.2	1.5	1.2	4.3
119	United Kingdom	27	15	10	2.9	4.5	4.0	2.0	2.8	2.7	1.8	1.8	2.0	0.0
120	Australia	24	13	9	3.1	4.1	4.0	2.2	1.7	3.3	2.0	1.8	2.5	1.2
121	Canada	33	13	9	4.7	4.1	4.1	3.3	2.3	3.8	1.7	1.6	4.0	0.7
122	France	34	12	9	5.2	3.2	3.9	3.7	1.2	2.8	1.9	1.8	1.9	0.6
123	German Dem. Rep.	45	15	9	5.5	5.7	4.2	. .	. .	2.4	1.8	1.7	1.4	0.6
124	Switzerland	27	12	9	4.1	3.2	4.0	1.5	1.6	2.4	1.5	1.5	2.4	0.0
125	Hong Kong	64	15	8	7.3	7.0	4.3	6.2	5.7	5.0	2.1	1.2	4.3	6.2
126	Netherlands	21	11	8	3.2	3.5	4.1	2.7	1.1	3.1	1.5	1.6	3.6	-0.7
127	Finland	28	9	7	5.7	2.8	4.0	3.6	2.7	2.7	1.7	1.6	2.3	0.7
128	Sweden	20	9	7	4.0	2.8	4.0	2.0	1.9	2.3	1.7	2.0	1.5	-1.8
129	Japan	39	11	6	6.3	6.7	4.3	5.1	3.4	2.0	1.8	1.7	0.5	0.6

Footnotes to Tables

Table 1: Basic Indicators

Afghanistan	GNP per capita	1987
Albania	GNP per capita	1987
Angola	GNP per capita	1987
Argentina	Household income	1970
Bulgaria	GNP per capita	1980
Cuba	GNP per capita	1987
Czechoslovakia	GNP per capita	1980
Ethiopia	Adult literacy	1986
German Dem. Rep.	GNP per capita	1980
Iran, Islamic Rep. of	GNP per capita	1987
Iraq	GNP per capita	1987
Korea, Dem. Rep. of	GNP per capita	1987
Lebanon	GNP per capita	1987
Liberia	GNP per capita	1987
Mongolia	GNP per capita	1987
Myanmar	GNP per capita	1987
Nicaragua	GNP per capita	1987
Panama	Household income	1973
Portugal	Household income	1973-74
Romania	GNP per capita	1983
Tanzania	Adult literacy	1986
	Household income	1969
Turkey	Household income	1973
USSR	GNP per capita	1980
Viet Nam	GNP per capita	1987

Table 2: Nutrition

Algeria	Underweight	0-71 months
	Stunting	24-71 months
Angola	Low birth-weight	Luanda only
Australia	Low birth-weight	1979
Bangladesh	Breast-feeding	1975-6
	Underweight	6-59 months
Bhutan	Underweight	0-60 months
	Wasting	0-60 months
	Stunting	0-60 months
Bolivia	Underweight	3-36 months
	Stunting	24-36 months
Botswana	Wasting	Clinic data
	Stunting	Clinic data
Brazil	Underweight	Gomez
	Wasting	North-East only
	Stunting	North-East only
Burundi	Low birth-weight	Bujumbura only
	Underweight	3-36 months
	Stunting	24-36 months
Cameroon	Low birth-weight	Yaounde only
	Breast-feeding	1978
	Underweight	1978; 3-47 months
	Wasting	1978
	Stunting	1978
Chile	Underweight	0-71 months
	Stunting	24-71 months
China	Underweight	9 provinces
	Wasting	9 provinces
	Stunting	9 provinces
Colombia	Underweight	3-36 months
	Stunting	24-36 months
Côte d'Ivoire	Low birth-weight	1975; Abidjan only
Cuba	Wasting	Lowest 3 percentiles; 12-59 months
Dominican Rep.	Underweight	6-36 months
	Stunting	24-36 months
Egypt	Underweight	3-35 months
	Stunting	24-35 months
Ethiopia	Underweight	Data from 9 zones
	Wasting	Data from 9 zones
	Stunting	Data from 9 zones
Finland	Breast-feeding	1972
Guatemala	Underweight	3-36 months
	Stunting	24-36 months

continued over

Haiti	Low birth-weight	1978
	Underweight	1978; Gomez; 3-59 months
	Wasting	1978
	Stunting	1978
Honduras	Wasting	0-59 months
	Stunting	0-59 months
India	Underweight	Gomez; 12-71 months
Indonesia	Underweight	Moderate & severe <80% median Severe <60% median
Iran, Islamic Rep. of	Underweight	National rural
	Wasting	National rural
	Stunting	National rural
Italy	Low birth-weight	1973
Jordan	Low birth-weight	1979
Kenya	Breast-feeding	1977-8
	Stunting	National rural
Korea, Rep. of	Breast-feeding	1978
Kuwait	Breast-feeding	1978-9
Lao People's Dem. Rep.	Breast-feeding	5 provinces only
Madagascar	Underweight	0-23 months
	Stunting	12-23 months
Mali	Underweight	3-36 months
	Stunting	24-36 months
Mauritania	Wasting	13-24 months
	Stunting	25-59 months
Mauritius	Wasting	0-59 months
	Stunting	0-59 months
Mexico	Low birth-weight	1978
	Breast-feeding	1979
Morocco	Underweight	0-36 months
	Stunting	24-36 months
Myanmar	Underweight	0-35 months
	Stunting	24-35 months
Nepal	Breast-feeding	1976
Netherlands	Breast-feeding	Exclud. Amsterdam & Rotterdam
Niger	Wasting	0-59 months
	Stunting	0-59 months
Nigeria	Wasting	National rural; 0-59 months
Pakistan	Underweight	Moderate & severe <80% median Severe <60% median
	Wasting	<80% of median; 13-24 months
	Stunting	<90% of median; 25-60 months
Papua New Guinea	Low birth-weight	1979
Philippines	Underweight	Severe <60% median
Poland	Breast-feeding	1977
Rwanda	Low birth-weight	1971
Saudi Arabia	Low birth-weight	Riyadh only
Senegal	Low birth-weight	1980-1; Dakar only
	Breast-feeding	1978
	Underweight	6-36 months
	Stunting	24-36 months
Sierra Leone	Underweight	1977-8
	Wasting	1977-8
Singapore	Underweight	1970-7; 0-71 months
	Wasting	1970-7; 0-71 months
	Stunting	1970-7; 0-71 months
South Africa	Low birth-weight	Capetown only
Sri Lanka	Underweight	3-36 months
	Stunting	24-36 months
Sudan	Wasting	Northern part; 0-59 months
Switzerland	Low birth-weight	1979
Syrian Arab Rep.	Breast-feeding	1978
Thailand	Underweight	3-36 months
	Stunting	24-36 months
Togo	Underweight	0-36 months
	Stunting	24-36 months
Trinidad and Tobago	Underweight	3-36 months
	Stunting	24-36 months
Tunisia	Underweight	3-36 months
	Stunting	24-36 months
Uganda	Underweight	0-60 months
	Stunting	24-60 months

continued over

United Arab Emirates	Low birth-weight	1979
Uruguay	Underweight	0-71 months
	Stunting	0-71 months
Venezuela	Breast-feeding	1977
	Underweight	0-60 months
	Wasting	13-24 months
	Stunting	25-60 months
Viet Nam	Stunting	0-59 months
Yemen	Breast-feeding	Combined countries estimate
	Underweight	Combined countries estimate
	Wasting	Combined countries estimate
	Stunting	Combined countries estimate
Zambia	Low birth-weight	1971-2; Kitwe only
Zimbabwe	Low birth-weight	1972-3; Harare only
	Underweight	3-60 months
	Stunting	24-60 months

Gomez:	moderate & severe - below 75% of median weight for age of reference population; severe - below 60% of median weight for age of reference population.

Table 3:
Health

Angola	Access to health services	1980
Australia	Measles	1987
Botswana	Access to health services	1980
Burkina Faso	Access to health services	1980
Canada	DPT, Polio	1987
	Measles	Aged 1-5 years.
Costa Rica	Access to health services	1980
Côte d'Ivoire	Access to health services	1980
Gabon	Access to health services	1983
	Access to safe water	1983
Germany, Fed. Rep. of	DPT	DT only
Hong Kong	Access to health services	1984
	Access to safe water	1984
Ireland	TB	1985
Italy	DPT	DT only
Japan	TB, DPT, Measles	1985
Mauritania	Access to health services	1980
Mexico	Access to health services	1980
New Zealand	TB, DPT, Polio, Measles	1987
Panama	Access to health services	1980
Paraguay	Access to health services	1980
Romania	TB	1987
Rwanda	Access to health services	1980
Singapore	Measles	Aged 1-5 years.
Somalia	Access to health services	1980
Sri Lanka	Access to health services	1980
Sudan	TB, DPT, Polio, Measles, Tetanus	Part of country only
Sweden	DPT	1987, DT only
	Polio	1987
Switzerland	TB	1986
Syrian Arab Rep.	Access to safe water	1980
	Access to health services	1980
Tanzania	Access to health services	1980
Tunisia	Access to health services	1983
Uganda	Access to health services	1980
United Arab Emirates	Access to health services	1980
USSR	TB, DPT, Polio, Measles	1985-86
Zambia	Access to health services	1980

Table 4:
Education

Haiti	Adult literacy (1970)	1971
Hong Kong	Adult literacy (1970)	1971
Lebanon	Adult literacy (1970)	Age 10 years and older
Pakistan	Primary completion	1981
Paraguay	Adult literacy (1970)	1972
Tanzania	Adult literacy	1986

continued over

Uruguay	Adult literacy (1970)	1975
Zaire	Primary enrolment (net)	1983

Table 6:
Economic Indicators

Afghanistan	GNP per capita	1987
	Poverty level	1977
Albania	GNP per capita	1987
Algeria	Poverty level	1977
Angola	GNP per capita	1980
Bangladesh	Poverty level	1976-77
Bolivia	Poverty level	1975
Bulgaria	GNP per capita	1980
Burundi	Poverty level	1978
Cameroon	Poverty level	1979
Chad	Poverty level	1976
Cuba	GNP per capita	1987
Czechoslovakia	GNP per capita	1980
German Dem. Rep.	GNP per capita	1980
Guatemala	Poverty level	1978
Honduras	Poverty level	1978
Iran, Islamic Rep. of	GNP per capita	1987
Iraq	GNP per capita	1987
	Inflation rate	1980-87
Jordan	GNP per capita growth rate	1970-80
Korea, Dem. Rep. of	GNP per capita	1987
Kuwait	GNP per capita growth rate	1965-86
Lebanon	GNP per capita	1987
Liberia	GNP per capita	1987
Mali	GNP per capita growth rate	1967-80
	Poverty level	1975
Mongolia	GNP per capita	1987
Myanmar	GNP per capita	1987
	Poverty level	1978
Romania	GNP per capita	1983
Saudi Arabia	GNP per capita growth rate	1965-86
Sudan	Poverty level	1975
USSR	GNP per capita	1980
Viet Nam	GNP per capita	1987

Table 7:
Women

Afghanistan	Maternal mortality	1975
Algeria	Contraceptive prevalence	1977
Australia	Births attended	1982
Austria	Contraceptive prevalence	Marriage cohorts of 1974 & 1978
Belgium	Contraceptive prevalence	Flemish population
Bulgaria	Contraceptive prevalence	1976
Cameroon	Contraceptive prevalence	1978
	Maternal mortality	1978
Chad	Contraceptive prevalence	1977
	Births attended	1981
Chile	Contraceptive prevalence	1978
Costa Rica	Births attended	1975
Czechoslovakia	Contraceptive prevalence	Ever used while married
Denmark	Births attended	1979
Finland	Contraceptive prevalence	1977
	Births attended	1979
France	Contraceptive prevalence	1978
	Births attended	1976
German Dem. Rep.	Births attended	1977
Germany, Fed. Rep. of	Births attended	1979
Greece	Births attended	1978
Guinea	Contraceptive prevalence	1977
Hungary	Births attended	1982
Iran, Islamic Rep. of	Contraceptive prevalence	1976
Israel	Births attended	1980; institutional deliveries
Italy	Contraceptive prevalence	1979; since last pregnancy
	Births attended	1979

continued over

Kenya	Maternal mortality	1977
Korea, Rep. of	Births attended	1982
Lesotho	Contraceptive prevalence	1977
Libyan Arab Jamahiriya	Births attended	1976
	Maternal mortality	1978
Malawi	Maternal mortality	All health institutions
Morocco	Births attended	1980
	Maternal mortality	1974
Netherlands	Contraceptive prevalence	Married women 21-39 years
	Births attended	1978
New Zealand	Contraceptive prevalence	1976
Niger	Contraceptive prevalence	1977
Nigeria	Births attended	1980
Norway	Contraceptive prevalence	1977; during past 4 weeks
	Births attended	1974
Pakistan	Births attended	1976
Poland	Contraceptive prevalence	1977
	Births attended	1980
Portugal	Contraceptive prevalence	1979
	Births attended	1978
Romania	Contraceptive prevalence	1978
	Births attended	1979
Rwanda	Maternal mortality	All hospitals
Senegal	Births attended	1978
South Africa	Maternal mortality	From 267 hospitals
Sudan	Tetanus	Part of country only
Sweden	Births attended	1976
Switzerland	Contraceptive prevalence	Marriage cohorts of 1970-79
	Births attended	1976
Syrian Arab Rep.	Contraceptive prevalence	1978
	Births attended	1979
Tanzania	Adult literacy	1986
	Contraceptive prevalence	1977
	Maternal mortality	From 48 hospitals, all regions
Thailand	Births attended	1980
Tunisia	Maternal mortality	1971
United Kingdom	Births attended	1978
Venezuela	Contraceptive prevalence	1977
	Births attended	1982
Yugoslavia	Contraceptive prevalence	1976; during last 6 months
	Births attended	1979
Zaire	Contraceptive prevalence	1977
Zambia	Contraceptive prevalence	1977
Zimbabwe	Maternal mortality	1979

Table 8: Basic Indicators on less populous countries

Antigua	Infant mortality rate	1985-90
	Births	1986
	Life expectancy	1985-90
Bahamas	Infant mortality rate	1985-90
	Births	1988
	Life expectancy	1985-90
Belize	Infant mortality rate	1985-90
	Births	1988
	Life expectancy	1985-90
British Virgin Islands	Infant mortality rate	1988
	GNP per capita	1987
	Adult literacy	1970
Brunei Darussalam	Infant mortality rate	1985-90
	Births	1988
	GNP per capita	1987
	Life expectancy	1985-90
Comoros	Adult literacy	1980
Cook Islands	Infant mortality rate	1986
	Births	1986
	GNP per capita	1987
Cyprus	Adult literacy	1976
Djibouti	GNP per capita	1987
Dominica	Infant mortality rate	1985-90
	Births	1984

continued over

	Life expectancy	1985-90
	Adult literacy	1970
Fed States Micronesia	Infant mortality rate	1981
	Life expectancy	1985-90
	Adult literacy	1982
Grenada	Infant mortality rate	1985-90
	Births	1979
	Life expectancy	1985-90
Kiribati	Infant mortality	1985-90
	Life expectancy	1985-90
Maldives	Infant mortality rate	1985-90
	Births	1988
	Life expectancy	1985-90
	Adult literacy	1987
Marshall Islands	Infant mortality rate	1981
	Life expectancy	1985-90
	Adult literacy	1982
Montserrat	Infant mortality rate	1985-90
	Births	1986
	GNP per capita	1987
	Life expectancy	1985-90
	Adult literacy	1970
Palau	Infant mortality rate	1981
	Life expectancy	1985-90
	Measles	1985
Saint Lucia	Infant mortality rate	1985-90
	Life expectancy	1985-90
	Adult literacy	1970
Saint Vincent	Infant mortality rate	1985-90
	Births	1986
	Life expectancy	1985-90
Samoa	Infant mortality rate	1985-90
	Life expectancy	1985-90
Sao Tome and Principe	Infant mortality rate	1985-90
	Life expectancy	1985-90
	Adult literacy	1981
Seychelles	Infant mortality rate	1985-90
	Life expectancy	1985-90
Solomon Islands	Infant mortality rate	1985-90
	Births	1984
	Life expectancy	1985-90
St. Christopher-Nevis	Infant mortality rate	1985-90
	Births	1986
	Life expectancy	1985-90
Tonga	Infant mortality rate	1985-90
	Life expectancy	1985-90
Turks & Caicos Islands	Infant mortality rate	1982
	Births	1982
	GNP per capita	1987
	Adult literacy	1970
Vanuatu	Infant mortality rate	1985-90
	Life expectancy	1985-90
	Adult literacy	1979

Table 9: The rate of progress

Jordan	GNP per capita growth rate	1970-80
Kuwait	GNP per capita growth rate	1965-86
Mali	GNP per capita growth rate	1967-80
Saudi Arabia	GNP per capita growth rate	1965-86

Definitions

Under five mortality rate:	annual number of deaths of children under five years of age per 1,000 live births. More specifically this is the probability of dying between birth and exactly five years of age.
Infant mortality rate:	annual number of deaths of infants under one year of age per 1,000 live births. More specifically this is the probability of dying between birth and exactly one year of age.
GNP:	gross national product. Annual GNP's per capita are expressed in current United States dollars. GNP per capita growth rates are average annual growth rates that have been computed by fitting trend lines to the logarithmic values of GNP per capita at constant market prices for each year of the time period.
Life expectancy at birth:	the number of years new-born children would live if subject to the mortality risks prevailing for the cross-section of population at the time of their birth.
Adult literacy rate:	percentage of persons aged 15 and over who can read and write.
Primary and secondary enrolment ratios:	The gross enrolment ratio is the total number of children enrolled in a schooling level - whether or not they belong in the relevant age group for that level - expressed as a percentage of the total number of children in the relevant age group for that level. The net enrolment ratio is the total number of children enrolled in a schooling level who belong in the relevant age group, expressed as a percentage of the total number of children in that age group.
Income share:	percentage of household income received by the highest 20% and lowest 40% of households.
Low birth weight:	2,500 grammes or less.
Breast-feeding:	percentage of mothers either wholly or partly breast-feeding.
Underweight:	*moderate and severe* - below minus two standard deviations from median weight for age of reference population; *severe* - below minus three standard deviations from median weight for age of reference population.
Wasting:	*moderate and severe* - below minus two standard deviations from median weight for height of reference population.
Stunting:	*moderate and severe* - below minus two standard deviations from median height for age of reference population.
Access to health services:	percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour.
DPT:	diphtheria, pertussis (whooping cough) and tetanus.
ORT use:	percentage of all cases of diarrhoea in children under five years of age treated with oral rehydration salts or an appropriate household solution.
Children completing primary school:	percentage of the children entering the first grade of primary school who successfully complete that level in due course.
Crude death rate:	annual number of deaths per 1,000 population.
Crude birth rate:	annual number of births per 1,000 population.
Total fertility rate:	the number of children that would be born per woman, if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.
Urban population:	percentage of population living in urban areas as defined according to the national definition used in the most recent population census.
Absolute poverty level:	the income level below which a minimum nutritionally adequate diet plus essential non-food requirements is not affordable.
ODA:	official development assistance.
Debt service:	the sum of interest payments and repayments of principal on external public and publicly guaranteed debts.
Contraceptive prevalence:	percentage of married women age 15-49 currently using contraception.
Births attended:	percentage of births attended by physicians, nurses, midwives, trained primary health care workers or trained traditional birth attendants.
Maternal mortality rate:	annual number of deaths of women from pregnancy related causes per 100,000 live births.

Main sources

Under five and infant mortality:	United Nations Population Division, United Nations Statistical Office and World Bank.
Total population:	UnitedNationsPopulationDivision.
Births:	United Nations Population Division and United Nations Statistical Office.
Under five deaths:	United Nations Population Division and UNICEF.
GNP per capita:	World Bank and Organisation for Economic Co-operation and Development (OECD).
Life expectancy:	United Nations Population Division.
Adult literacy:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
School enrolment and completion:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
Household income:	World Bank.
Low birth-weight:	World Health Organization (WHO).
Breast-feeding:	World Health Organization (WHO).
Underweight, wasting and stunting:	World Health Organization (WHO) and Demographic and Health Surveys, IRD.
Food production and calorie intake:	Food and Agricultural Organization of the United Nations (FAO).
Income spent on food:	World Bank.
Access to drinking water:	World Health Organization (WHO).
Access to health services:	UNICEF.
Immunization:	World Health Organization (WHO) and UNICEF.
ORT use:	World Health Organization (WHO).
Radio and television:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
Child population:	United Nations Population Division.
Crude death and birth rates:	United Nations Population Division.
Fertility:	United Nations Population Division.
Urban population:	United Nations Population Division.
Inflation and absolute poverty level:	World Bank.
Expenditure on health, education and defense:	World Bank and International Monetary Fund (IMF).
ODA:	Organisation for Economic Co-operation and Development (OECD).
Debt service:	World Bank.
Contraceptive prevalence:	United Nations Population Division and Rockefeller Foundation.
Births attended:	World Health Organization (WHO).
Maternal mortality:	World Health Organization (WHO).

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THE STATE OF THE WORLD'S CHILDREN 1991

On September 30th, 1990, the World Summit for Children brought together the largest gathering of Presidents and Prime Ministers in history. The outcome was a promise to the children of the 1990s – a promise to end child deaths and child malnutrition on today's scale by the year 2000 – and to provide basic protection for the normal physical and mental development of all the world's children.

As the Summit met, the world was nearing the deadline, set just over ten years ago, for the achievement of another great human goal – the immunization of 80% of the developing world's children. That goal is expected to have been reached when the final figures for 1990 become available. This extraordinary achievement has saved over 12 million young lives and prevented over one and a half million children from being crippled by polio. It has also given the world new hope by showing what can be achieved when the international community commits itself to a great endeavour.

The Declaration and Plan of Action adopted by the Summit is published with this year's *State of the World's Children* report, as is the full text of the Convention on the Rights of the Child. The report's panels describe all 22 of the specific goals for the year 2000 and show why they are now attainable and affordable. This year's report therefore serves as a basic record of the commitment made by the world community, in respect of its children, for the decade ahead.

The report itself looks at how the year 2000 goals fit into an overall strategy of development in the 1990s and at the question of where the resources will have to come from if the great promise is to be kept.

In chapter 5, the report addresses the question of whether success in reducing child deaths would serve only to add to population and environmental pressures. Its conclusion is that the achievement of the year 2000 goals would help to bring about a stabilization of population growth at an earlier date and at a lower level.

The great effort called for can only be sustained, concludes the report, if a new ethic for children emerges in the 1990s – *"an ethic which grants children a first call on our societies resources in good times and in bad; an ethic which demands that children should be the first to benefit from mankind's successes and the last to suffer from its failures."*

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CHILDREN
1991

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United Nations Children's Fund
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THE STATE OF THE WORLD'S CHILDREN
1991

A Summary

The following is a summary of the State of the World's Children report for 1991, issued by the Executive Director of UNICEF, James P. Grant. For details of the full report, please see back cover.

On Sunday, September 30th, 1990, a great promise was made to the children of the 1990s. On that day, 71 Presidents and Prime Ministers came together for the first World Summit for Children. It was the largest gathering of heads of state and government in history. And the outcome was an extraordinary new commitment - a decision to try to end child deaths and child malnutrition on today's scale by the year 2000 - and to provide basic protection for the normal physical and mental development of all the world's children.

This overall goal was broken down into more than 20 specific targets listed in the Plan of Action agreed on by the 159 nations represented at the Summit. All governments will review their plans and budgets and decide on national programmes of action before the end of 1991.

"*We are prepared to make available the resources to meet these commitments*", said the final Declaration. All national and international organizations have been asked to participate. In particular, the worlds of religion, education, the communications media, business, and the non-governmental organizations in every country are invited to join this decade-long effort.

As the Summit met, the world was nearing the deadline set just over 10 years ago for reaching another great human goal - 80% immunization coverage for the children of the developing world. At the time, approximately 15% were being immunized. Today, despite all the difficulties of the last decade, the 80% goal is expected to have been reached when the latest figures become available early in 1991.

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* The goal of immunizing 80% of children under the age of one is expected to have been reached for the developing world as a whole on the basis of the percentage of infants who have received the necessary three shots of DPT vaccine (considered by WHO and UNICEF to be a good indicator of the effectiveness of the immunization system as a whole). For BCG, the target has already been surpassed. For Polio (three shots) overall coverage of 78% by 1989 is expected to rise beyond the 80% target by the end of 1990. Measles immunization, which is not normally given before the age of nine months and which began the decade at very low levels, reached 71% in 1989 and may still lag a few percentage points behind as 1990 ends.

The diseases which vaccines prevent are also major causes of child malnutrition; the immunization effort of the last decade has therefore also kept uncounted millions of children from the downward spiral of frequent illness, poor growth and early death.

The year 2000: what can be achieved?

The following is the full list of goals, to be attained by the year 2000, which were adopted by the World Summit for Children on September 30th 1990. After widespread consultation among governments and the agencies of the United Nations, these targets were considered to be feasible and financially affordable over the course of the decade ahead.

Overall goals 1990-2000

○ A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births - whichever is less).

○ A halving of maternal mortality rates.

○ A halving of severe and moderate malnutrition among the world's under-fives.

○ Safe water and sanitation for all families.

○ Basic education for all children and completion of primary education by at least 80%.

○ A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.

○ Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted *Convention on the Rights of the Child*. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

Protection for girls and women

○ Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'.

○ All women to have access to pre-natal care, a trained attendant during childbirth and referral for high-risk pregnancies and obstetric emergencies.

○ Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy and lactation.

Nutrition

○ A reduction in the incidence of low birth weight (2.5 kg. or less) to less than 10%.

○ A one-third reduction in iron deficiency anaemia among women.

○ Virtual elimination of vitamin A deficiency and iodine deficiency disorders.

○ All families to know the importance of supporting women in the task of exclusive breast-feeding for the first four to six months of a child's life and of meeting the special feeding needs of a young child through the vulnerable years.

○ Growth monitoring and promotion to be institutionalised in all countries.

○ Dissemination of knowledge to enable all families to ensure household food security.

Child health

○ The eradication of polio.

○ The elimination of neonatal tetanus (by 1995).

○ A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.

○ Achievement and maintenance of at least 85% immunization coverage of one-year-old children and universal tetanus immunization for women in the child-bearing years.

○ A halving of child deaths caused by diarrhoea and a 25% reduction in the incidence of diarrhoeal diseases.

○ A one-third reduction in child deaths caused by acute respiratory infections.

○ The elimination of guinea worm disease.

Education

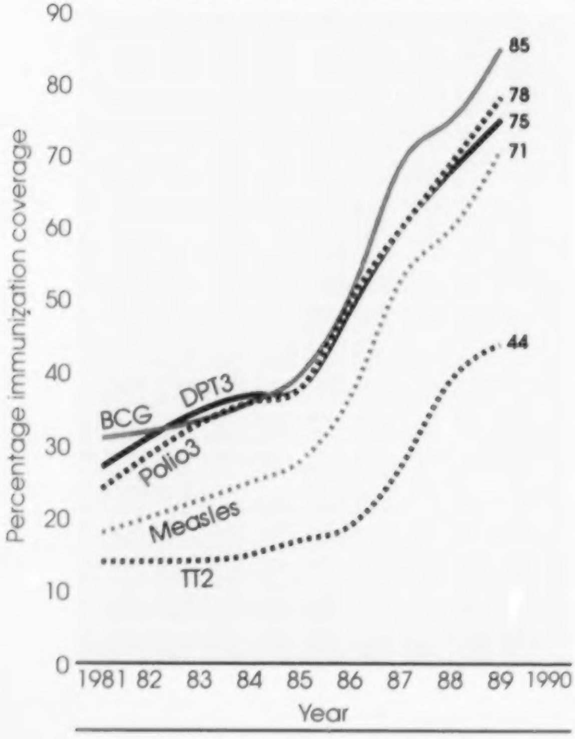
○ In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.

That extraordinary effort has saved over 12 million young lives and prevented over one and a half million children from being crippled by polio.

It has also given the world new hope by showing what can be achieved when the international community commits itself to a great endeavour.

Increase in immunization coverage for infants in developing countries, 1981-89

The graph shows the developing world's progress towards the target of 80% immunization by the end of 1990. Figures for 1990 will be available in early 1991. China is not included in the data until 1986.



TT2 = two anti-tetanus injections, during pregnancy, to protect against tetanus of the new-born.

Source: WHO and UNICEF

The quiet catastrophe

Two principal facts dominated the World Summit for Children.

The first was the fact of the quiet catastrophe - the 40,000 child deaths each day from ordinary malnutrition and disease, the 150 million children who live on with ill health and poor growth, the 100 million 6 to 11-year-olds who are not in school.

The second was the fact that the means of ending this quiet catastrophe are now both available and affordable. Large-scale trials and studies in many nations in recent years have vastly increased both the world's understanding of the problems and its capacity to solve them.

The question at the centre of the World Summit was therefore whether morality would keep step with capacity, whether what *could* now be done *would* now be done.

That question could not be answered at the Summit itself. For it is a question which will be answered not by the declarations of a day but by the deeds of a decade.

The goals

The seven overarching goals adopted for the year 2000 by the Summit may be summarized as follows:

○ *Reduction of 1990 under-five child mortality rates by one third or to a level of 70 per 1,000 live births, whichever is the greater reduction.*

At present, approximately 14 million children under five are dying each year in the developing world - more than a quarter of a million each week. The immediate causes of more than 60% of those deaths can be numbered on the fingers of one hand - diarrhoeal disease, measles, tetanus, whooping cough and pneumonia. All of these can now be prevented or treated at very low cost. Several countries with per capita GNPs of under $1,500 a year - including Chile, China, Jamaica, Mauritius, Sri Lanka and Thailand - have already succeeded in reducing under-five death rates to less than 50 per 1,000.

Child survival: and population growth

> *"The surest way to achieve a sustained decline in fertility is to give a new priority to 'social' or 'women's resources' investment, to improving mother and child health, women's status and education and to making family planning as widely available as possible to both women and men."*
>
> *The State of World Population 1990,*
> Dr. Nafis Sadik, Executive Director,
> United Nations Population Fund

Doing what can now be done to reduce child deaths in the developing world would also help to slow population growth. Some of the reasons:

The physiological factor

An infant death means the end of breast-feeding, an important 'natural contraceptive'.

The replacement factor

The death of a young child prompts many couples to replace the loss of the child by a new pregnancy. Studies in Bangladesh show that an infant death reduces the average interval between births from more than three years to less than two. Families which experience the death of a child are much less likely to use any method of birth planning.

The insurance factor

When child death rates are high, parents often insure against an anticipated loss by having more children. Planning on the basis of the worst that can happen, rather than on the basis of statistical probabilities, often means over-compensation and an average family size greater than desired.

The confidence factor

Empowering parents with today's child survival knowledge helps build the confidence which is so crucial a factor in the acceptance of family planning. As the UN Population Division has concluded, "Any given improvement in mortality will be more likely to initiate fertility control behaviour among those who understand and participate in that improvement than among those who do not".

The direct effect of child survival strategies

Three of the most important means now available for reducing child deaths are also among the most powerful means of reducing birth rates:

○ Promoting the knowledge that children can be protected by exclusive breast-feeding for the first four to six months will also help to lower birth rates, because breast-feeding is one of the most effective ways of preventing pregnancy during that period.

○ Most child deaths happen to mothers who are younger than 18 or older than 35, who have had more than four children already or who give birth less than two years after a previous delivery. Promoting knowledge about the importance of timing births, and providing the means to act on it, is therefore one of the most powerful child survival strategies - and also reduces birth rates.

○ Female education, in addition to the advantages it can bring to women, improves child health and survival. Educated mothers are also more likely to opt for smaller families.

The synergism between this array of child survival actions and effective family planning programmes means that the two together can bring about population stabilization at an earlier date and at a lower level than either acting alone. The 1990s offer a remarkable opportunity to use this synergism, as many developing countries are now at the critical 'point of parental confidence' where further reductions in child deaths are likely to bring even greater reductions in births.

The experience of individual countries shows the power of this combination. If all countries were to achieve the same under-five death rates and the same birth rates as Chile or Sri Lanka, for example, then the world would see approximately 10 million fewer deaths each year - and approximately 20 million fewer births.

○ *Reduction of maternal mortality rates to half of 1990 levels.*

At present, approximately 500,000 women are dying every year - one young woman each minute - because something has gone wrong in pregnancy or childbirth. Many of those deaths follow long hours of agony and fear. And many of those women leave behind motherless children. At least half of all maternal deaths could now be prevented by elementary, low-cost means.

○ *Reduction of severe and moderate malnutrition among under-five children by one half of 1990 levels.*

At present, one child in every three in the developing world is prevented from growing to his or her mental and physical potential by persistent malnutrition. Many parents are unable to feed their children adequately because of war or famine or because they do not have the land to grow food or the jobs and the income to buy it. But the majority of child malnutrition occurs in households where there is sufficient food. The cause is the frequency of illness and a lack of knowledge about the special feeding needs of the young child. Today's knowledge about birth spacing, breast-feeding, weaning, growth promotion, and the prevention and treatment of common illnesses, plus well-targeted food supplements, has shown that the problem of mass child malnutrition can be overcome at an average annual cost of approximately $10 per child.

○ *Universal access to safe drinking water and to sanitary means of excreta disposal.*

At present, more than one third of all families in the rural areas of the developing world do not have access to clean water and one half do not have safe sanitation. Yet costs have fallen dramatically in the last decade. The average initial investment required to provide both safe water and sanitation is now less than $30 per person, and the recurring cost can be as low as $1 or $2 per person per year.

○ *Universal access to basic education and completion of primary education by at least 80% of primary school age children.*

At present, only 55% of children in the developing world complete four years of primary education. Boys have twice as much chance of becoming literate as girls, despite the fact that the education of girls is probably the best single investment that any country can make in its future health and well-being. In recent years, low-cost strategies have succeeded in providing the vast majority of children with at least five years of basic education even in some of the world's poorest countries.

○ *Reduction of the adult illiteracy rate to at least half its 1990 level, with emphasis on female literacy.*

At present, there are over 900 million adults in the world who cannot read or write. Two thirds of them are women.

○ *Protection of children in especially difficult circumstances, particularly in situations of armed conflicts.*

At present, an estimated 80 million children are exploited in the workplace and 30 million are left to fend for themselves on city streets. Millions more are victims of war, their development disrupted by the interruption of food supplies, the closing of schools and clinics, and the destruction of homes, roads and crops.

A practical investment

This range of goals for the year 2000 will clearly be more difficult to accomplish, by several orders of magnitude, than any targets previously attempted. It will demand an extraordinary effort, stepped up over the next two years and sustained throughout the decade, by individual nations, by the United Nations family, by the international community, and by non-governmental organizations and members of the public in every country.

But if the demands are great, then so are the incentives. Basic protection for the lives and the normal growth of all the world's children is not only the greatest of all humanitarian causes; it is also the greatest of all practical investments.

It is a practical investment because vast numbers of unnecessary child deaths increase population growth by pushing millions of parents into having more children than they want in order that some may survive.

It is a practical investment because persistent malnutrition saps the physical and mental development of people and, ultimately, the economic and social development of nations.

It is a practical investment because even four years of basic education can make a significant difference to productivity and incomes as well as to child health and the acceptance of family planning.

It is a practical investment because basic education for every child is also a fundamental prerequisite for environmentally sound development in the years to come. The choices which today's children will have to make in the twenty-first century, whether they be choices about family size or land use, energy source or waste disposal, can only be made wisely by a population which is capable of absorbing new knowledge and responding to it. Environmentally sustainable human development will therefore depend in large measure on the level of commitment which is made to education in the decade ahead.

Finally, it is a practical investment because communications technology has ensured that the children born into the 1990s will know more about the world and expect more from it than any previous generation. And if there is one lesson which history insists on, it is that political and social turmoil will follow when persistent poverty and personal tragedy sit side by side with the evident capacity for improvement in the lives of the poor.

The achievement of the goals decided on at the World Summit for Children, however difficult and daunting the prospect, would therefore represent not only one of the greatest humanitarian achievements of this or any other century, but also one of the greatest practical investments which the human race could now make in its future economic prosperity, political stability, and environmental integrity.

The best chance we have

The specific goals which make up this investment have been decided on after a long process of consultation, and endorsed by 159 governments at the largest gathering of political leaders ever assembled. They therefore represent the best chance the world has, in the decade ahead, for a unifying framework of action and a worldwide mobilization by governments, international agencies, educators, religious leaders, health professionals, voluntary organizations, the mass media, the business community, and members of the public.

The goals are undoubtedly ambitious. But while recognizing the difficulties, it is also important to recognize that these are the goals which are the most achievable, the goals for which the knowledge and the technology already exist, the goals which can be achieved at minimum financial and political cost, the goals which, if they are not achieved, will make a mockery of our hopes of meeting the broader challenges of environmentally sustainable human development in the twenty-first century.

Keeping the promise

Among the tens of thousands of words which appeared in the world's press following the Summit for Children, one persistent strain was summed up by an editorial in *The New York Times*:

> *"The largest global Summit meeting in history pledged to do better by the world's children. Their promises were eloquent, their goals ambitious. But children cannot survive or thrive on promises. The world's leaders now have an obligation to find the resources and the political will necessary to translate hope into reality."*

In short, can the promise be kept?

That question, and particularly the question of whether the resources can be found, is bound up with the broader picture of economic development in the 1990s.

The economic context

Economic progress in the decade ahead is not the only factor which will influence the progress of nations towards the year 2000 goals. It may not even be the most important factor. Several developing countries have already achieved the goals for under-five mortality and school enrolment despite per capita incomes which are significantly lower than the average for the developing world.

Nonetheless, for most countries, economic progress would make it considerably easier to devote the necessary resources to the task.

The bad news is that the developing world's debt still stands at approximately $1,300 billion, that annual interest repayments on that debt amount to almost $200 billion, that interest and amortization payments exceed new net flows from the industrialized countries by $30 billion, that aid levels are increasing only marginally, and that primary commodity prices are still at their lowest level since the 1930s.

Debt, in particular, still shackles many developing nations, claiming a large proportion of the resources which might otherwise have been available for investment in human progress. With falling family incomes, and cuts in public spending on services such as health and education, many African and Latin American children are still paying heavily for their nations' debts; and the currency they are paying with is their opportunity for normal growth, their opportunity to be educated, and often *their lives*. With no less urgency than at any time in the last five years, UNICEF must again say that it is the antithesis of civilization that so many millions of children should be continuing to pay such a price.

The better economic news is that projections for the 1990s show the industrialized nations growing at an average 3% per annum and the developing nations growing at just over 5% per annum. Such forecasts, even should they prove accurate, screen great disparities. Most of Asia should see continued steady progress, accompanied by a significant fall in the numbers of the absolute poor. Latin America, the Middle East and North Africa are expected to see slower growth with a smaller reduction in the numbers of the poor. Sub-Saharan Africa, facing rapid population growth as well as economic stagnation and severe ecological problems, will struggle to maintain per capita incomes; without debt cancellation, a renewal of investment, and an increase in real aid, the sub-continent may well see an increase in the numbers living in poverty during the decade ahead.

Development strategy

After 40 years of conscious and often contentious debate about strategies of development, there is perhaps more unanimity on the subject as the 1990s begin than at any previous time. The 1990 World Bank report has summed up the emerging consensus:

Proportion of ODA going to basic health and education, 1986-87

Less than 25% of the industrialized world's aid is devoted to health and education, and this proportion has fallen by about one third over the last decade. Three of the most basic elements of human development – primary health care, primary education, and rural water supply and sanitation – receive only just over 3% of all aid.

Allocation of official development assistance (ODA) 1986-87

Health (inc.family planning)	**5.0%**
Primary health care	**1.5%**
Education	**11.0%**
Primary education	**1.0%**
Water and sanitation	**6.0%**
Rural water and sanitation	**1.0%**

Source: OECD/DAC 1989. Figures based on detailed sector reporting from OECD Credit Reporting System Data Base (which covers bi-lateral technical assistance only partially).

"The evidence in this Report suggests that rapid and politically sustainable progress on poverty has been achieved by pursuing a strategy that has two equally important elements. The first element is to promote the productive use of the poor's most abundant asset - labor. It calls for policies that harness market incentives, social and political institutions, infrastructure, and technology to that end. The second is to provide basic social services to the poor. Primary health care, family planning, nutrition, and primary education are especially important.

"The two elements are mutually reinforcing; one without the other is not sufficient."

It is in the second part of this 'two-part strategy for development' that the goals adopted by the World Summit for Children find their place in the overall development effort of the 1990s. For the year 2000 goals are essentially a statement of the most obvious, achievable, and affordable elements in the task of investing in human capacity and providing basic social services to the poor.

The role of aid programmes

This overall context is especially important in considering the role which aid programmes might play in the years ahead.

In the *State of the World's Children* report two years ago, UNICEF proposed that:

"Aid can make it politically easier to take decisions of which the principal beneficiaries would be the poor, the environment, and the future.

"The time has come when not only aid but also debt reduction and trade agreements should form part of a real development pact by which participating industrialized nations would make a commitment to increase resources and participating developing nations would make a corresponding commitment to a pattern of real development which unequivocally puts the poor first.

"The ultimate aim and measure of that real development is the enhancement of the capacities of the poorest, their health and nutrition, their education and skills, their abilities to control their own lives, and their opportunities to earn a fair reward for their labours. This is the kind of development which the majority of people in the poor world seek and the majority of people in the industrialized world would support."

In similar vein, World Bank President Barber Conable has also said: "*The allocation of aid should be more closely linked to a country's commitment to pursue development programmes geared to the reduction of poverty*".

There could be no better measure of that commitment than progress towards the goals which a majority of the world's political leaders - from both industrialized and developing worlds - have already considered and endorsed.

In this way, the ambitious goals adopted at the World Summit for Children can contribute to the overall development effort of the decade ahead and provide a sharper focus for the industrialized world's aid. And it is in this context that we turn again to the initial question of where the resources might come from to fund this investment in today's children - and tomorrow's world.

Finding the resources

It is virtually impossible to calculate the overall financial cost of reaching all of the goals adopted at the World Summit for Children. But for the sake of bringing the cost into overall perspective, a 'best guess' would put the figure close to $20 billion a year for the next decade. To put this $20 billion a year into perspective, it is approximately one eighth of one per cent of the world's annual income. It is half as much as Germany will find for the process of national reunification in 1991. It is as much as the world spends on the military every 10 days. "*The financial resources required are modest*", says the Plan of Action adopted at the Summit, "*in relation to the great achievements that beckon.*"

Such comparisons are made almost every year in *The State of the World's Children* report. And they are made here again because it must never become accepted as normal and unremarkable that a fifth of mankind should be without adequate food, safe water, basic health care, and elementary education, or that millions of children should die or be stunted in brain and body, in a world which clearly has the knowledge and the resources to enable all its people to meet their own and their children's needs. However ritualistic such comparisons may seem, they serve to make a mockery of the idea that the world cannot yet afford to contemplate the great step forward for our civilization which would be represented by achieving the year 2000 goals and bringing basic protection to the lives and the growth of all its children.

But it is equally clear that such comparisons do not mean that $20 billion a year will be forthcoming for this purpose. On a practical basis, where might the money come from?

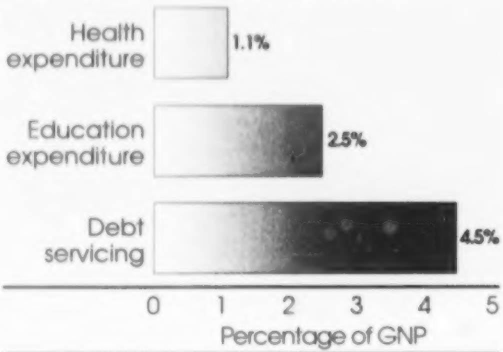
Overall, the developing countries will probably have to find about two thirds of that sum themselves.

The two major internal sources of such sums are the restructuring of present spending *in favour of the social sector* and the restructuring of present spending *within the social sector.*

To take the first of these, more than 25% of all present government expenditures in the developing world are devoted to the military, to inefficient state-controlled companies, and to subsidies which are not targeted to those most in need. Military spending is the greatest of these. The developing nations as a whole are now spending more on the military than on education and health combined*. With the ending of the cold war and the easing of regional tensions, it cannot be too unrealistic to suggest a 5% cut in defence spending - which would in itself liberate half of the estimated $20 billion a year needed to reach the year 2000 goals.

Health, education, and debt

The chart shows the percentage of Gross Domestic Product devoted to debt servicing as compared to spending on health and education in the 95 low and middle income developing countries during 1987, the latest year for which data are available



Source: World Development Report 1989. World Bank

'New' resources could also be found within the amounts which are already allocated to social services. In health, hospitals which reach at most 15% to 20% of the population often claim 80% of the budget. In education, more than half of all government spending is often allocated to secondary and higher education for the minority, usually from higher-income families. In water and sanitation schemes, 80% of the $10 billion now being invested each year is being devoted to schemes costing $550 or more per person, while less than 20% is being allocated to today's low-cost strategies costing less than $30 per person served. Relatively modest spending shifts from high per capita cost services, which generally serve the relatively better off, to low per capita cost strategies for the poor could therefore release enough to meet the developing world's share of the overall bill.

External aid

Approximately one third of the $20 billion needed might be expected to come from the industrialized world. And that contribution of an extra seven billion dollars a year could be made in many different ways.

First, debt relief might be specifically linked to investments in reaching the agreed goals.

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* This overall figure for the developing world hides wide regional disparities. Most Latin American nations, for example, spend less on the military than on health and education and many Middle Eastern countries spend considerably more.

Seven billion dollars is, after all, only as much as the industrialized world now receives from the developing world in debt repayments *every 10 days*. As the Plan of Action adopted at the World Summit for Children urges:

> "*Debt-relief schemes could be formulated in ways that the budget reallocations and renewed economic growth made possible through such schemes would benefit programmes for children. Debt relief for children, including debt swaps for investment in social development programmes, should be considered by debtors and creditors.*"

Increases in aid are another possibility; but more efficient use could be made of the $50 billion a year currently allocated. At the moment, far less than 25% of all the industrialized world's bilateral official development assistance is devoted to health and education, and this proportion has fallen by about 30% over the last decade.

Within this small and shrinking slice of the aid pie, it is again the higher cost services for the relatively better off which take the greater part. Aid for primary health care, including family planning, primary education, and rural water supply and sanitation, totals only just over 3% of the industrialized world's aid.

It would therefore require less than drastic changes in the orientation of existing aid programmes to release the resources needed to support the year 2000 goals. Even if only the projected *increases* in aid over the next few years were devoted to primary health care, primary education, and low-cost water and sanitation schemes, then the annual amount of aid available for these purposes would be *doubled* *.

Ideally, the process of making these relatively small shifts in spending - both in developing country budgets and in the industrialized world's aid budgets - would be a co-operative effort. Few changes could make the achievement of the year 2000 goals more likely than a series of compacts by which one or more developing countries made agreements with one or more industrialized countries on adequately funded plans for making measurable progress towards those goals.

As the Plan of Action adopted at the World Summit for Children recommends:

> *"Each country is urged to re-examine in the context of its particular national situation, its current national budget, and in the case of donor countries, their development assistance budgets, to ensure that programmes aimed at the achievement of goals for the survival, protection and development of children will have a priority when resources are allocated. Every effort should be made to ensure that such programmes are protected in times of economic austerity and structural adjustments."*

If the promise of the World Summit for Children is to be kept, then this re-examination of spending priorities in both industrialized and developing worlds will need to be completed no later than the end of 1991.

Commitment to the goals

The World Summit for Children, which was the culmination of a long process of consultation with governments and technical experts from all regions, has given a flying start to this process of establishing the year 2000 goals. But the declarations and commitments of political leaders are not enough. Goals must become the goals of society as a whole; and it is essential that, within the next few months, all organizations and individuals who share the dream of a world without preventable malnutrition and disease, a world which protects the lives, the growth, and the rights of its children, should also consider what part they might play in entrenching the year 2000 goals and in enlisting sustained support for them over the decade ahead. The Plan of Action adopted by the World Summit for Children specifically asks all national, regional, and international organizations, governmental and non-governmental, to "*examine how they can contribute to the achievement of the goals and strategies enunciated in the Declaration and this Plan of Action as part of more general attention to human development in the 1990s. They are requested to report their plans and programmes to their respective governing bodies before the end of 1991 and periodically thereafter.*"

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* Differences between the industrialized nations have also become more marked in recent years. Canada, Denmark, Finland, the Netherlands, Norway and Sweden, contribute roughly twice as much aid per capita as most industrialized countries, and their aid programmes are generally more biased towards basic services and poverty alleviation. If all aid-giving nations were to move in this direction, then the resources required to meet the year 2000 goals would quickly be subscribed.

The infrastructure

Another essential factor is the availability of low-cost technologies and strategies which reduce the costs involved and therefore the political will required. Goals must not only be technically possible but also politically and financially feasible. Much careful thought has already been given to this matter in the selection of the year 2000 goals, and the available techniques and strategies are discussed in the full text of the *State of the World's Children* report.

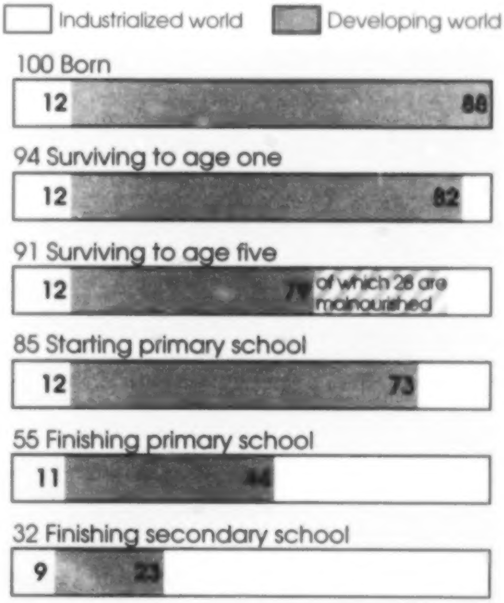
The more difficult question today is the means by which today's knowledge and technique can be put at the disposal of the majority. Many of the year 2000 goals are dependent on the delivery of low-cost *technologies* - be they vaccines, oral rehydration salts, antibiotics, growth charts, iron tablets or vitamin A supplements. Many also depend on the delivery of *knowledge* which can empower families themselves to take more control over their own health: today's knowledge about the importance of birth spacing, about special care in pregnancy and childbirth, about the importance of breast-feeding, about safe ways of weaning, about promoting normal growth, about preventing and coping with common illnesses, and about preventing the spread of AIDS - is knowledge which every family, and not just every health worker, should have.

Most of the year 2000 goals depend on the combination of both - on trained help and appropriate technologies and on empowering families with knowledge. The question of infrastructure, of the capacity to deliver, can therefore be considered in two overlapping parts.

In particular, it is the effective community health worker who can enable families to use today's knowledge for the improvement of their own and their children's lives. With a few months' basic training, supported by referral and supervision systems, a community health worker can offer advice and practical help with such things as birth spacing, pre-natal care, safe delivery, breast-feeding, weaning, feeding a child during and after illness, growth monitoring, disease prevention, immunization, oral rehydration therapy, the use of antibiotics against acute respiratory infections, and the distribution of vitamin A capsules, iron supplements or malaria tablets. *Such information and such techniques constitute a large part of what is required to meet the year 2000 goals of reducing child deaths by one third and child malnutrition*

The children of the 1990s

142 million children have been born into the world during 1990. The chart below presents this huge number as just 100 children and gives a schematic overview of what will happen to them in the decade ahead.



Source: UNICEF estimates based on United Nations projections *by half.* Yet the job can largely be done by community health workers who can be trained for as little as $500 (as opposed to fully qualified doctors whose training may cost $70,000 or more). It is therefore reasonable to assume that those countries which succeed in reaching the goals for the year 2000 will be those countries which also succeed in putting a well-trained, well-supervised, and well-supported community health worker within reasonable reach of every family.

The communications capacity

The other half of the 'infrastructure' question is a country's capacity to put new knowledge at people's disposal. And here, too, recent years have seen advances which could amount to nothing less than an information revolution *for the poor.* Rising literacy and the growth of newspapers, the spread of radio into almost every home and television into almost every community, the popularity of cinema and more recently the video theatre, the new outreach of religious leaders, the rise of the numbers enroled in school, the proliferation of non-governmental and voluntary organizations, the growth of professional societies, employers' associations, trade unions, and government services all mean that the capacity of the developing world to communicate with the majority of its people has been transformed. The task that remains is the mobilization of this new capacity in order to empower people with today's knowledge. "*All forms of social mobilization*", says the Plan of Action adopted at the World Summit, "*including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children.*"

In this sense, therefore, the question of whether or not the year 2000 goals can be achieved, whether or not the promise can be kept, is a question not just for governments but for the mass media, for the schools, for the churches, temples and mosques, for business and commerce, for the professional associations and the academic community, for the non-governmental organizations and the women's movements, for the employers' associations and the trade unions, for the youth organizations and the sports and entertainment industries.

In short, the question of whether the promise will be kept is a question for us all.

A new ethic for children

Targets and strategies alone will not achieve the year 2000 goals. All significant social change - be it the abolition of slavery, the spread of democracy, the end of colonialism, the discrediting of racism and apartheid, the advent of a new respect for the environment, or the struggle for female equality - has both required and stimulated a change in the prevailing ethical climate.

The goal of ending mass child deaths and mass child malnutrition, and of providing basic protection for the lives and the normal development of all children, is as difficult and significant a social change as any of the great changes that have gone before. And this dream, too, will be realized only with the wide acceptance of a new ethic for children.

The essence of a new ethic for children is the principle referred to in the Plan of Action adopted by the Summit as "*the principle of a 'first call for children' - a principle that the essential needs of children should be given high priority in the allocation of resources*".

The need for that new ethic arises, as ethics usually do, from practical as well as moral roots. The special vulnerability and the special responsiveness of the early years, demand that the child's one chance for normal growth should be given a *first call* on our concerns and capacities.

Those same reasons also demand that children should be able to count on that commitment in good times and in bad - in lean times and in times of plenty, in times of peace and in times of war, in times of recession or in times of steadily advancing prosperity. The mental and physical growth of a child cannot be asked to wait until interest rates fall, or until commodity prices recover, or until debt repayments have been rescheduled, or until the economy returns to growth, or until after a general election, or until a war is over. The ethic of first call for children does not demand that protection for the lives and the development of the young should be a priority; it demands that it should be an absolute. It does not demand the kind of commitment which can be superseded by other priorities that suddenly seem more urgent, but the kind of commitment that will not waver in the winds of change which will always blow across the world of human affairs.

There will always be something more immediate. There will never be anything more important.

In the past, it may often have been inevitable that the physical, mental and emotional development of children should be exposed to the slings and arrows of adult society. But in our time, for the first time, we have the chance to begin shielding the lives and the normal growth of children from the worst excesses, misfortunes, and mistakes of the world into which they are born. And the fact that our societies do not now do so will one day be regarded as being as strange and uncivilized as is the notion of slavery today.

All of this is directly relevant to the accomplishment of the goals which the world has now set for its children in the years ahead. For the principle of first call would demand that whether a child survives to adulthood, whether a child grows normally in mind or body, whether a child is well nourished, has health care, is immunized, has a school to go to, should not, by the year 2000, have to depend on such things as the balance of payments, or on the level of interest rates, or on fluctuations in the terms of trade, or on the election of any particular political party, or on any other of the inevitable turbulences of the adult world.

Like other great changes in prevailing ethic, the world-wide acceptance of this principle of first call for children will not come quickly or easily. But like other such changes, it will represent nothing less than an advance for civilization itself.

Conclusion

Despite the crises which continue to occur in international affairs, the ending of the cold war offers the possibility of a new era for mankind. The price of preoccupation with war has been more than financial; it has been a price paid in the distortion of our science and technology, in the absorption of our management and political skills, in the waste of our energies and ingenuities, and in the distraction of our vision and our imagination. The dividends of peace may also, therefore, be paid to the human race in many currencies, and above all in the liberation of financial and human resources for a renewal of what Robert Heilbroner, in the 1960s, called 'the great ascent'. In our times, the vision of a world in which every man, woman and child has adequate food, clean water, decent housing, modern health care, and a basic education, could at last be realized.

The World Summit for Children has given the world an extraordinary opportunity to take a series of concerted actions which would amount to the first steps on that long journey. It is an opportunity to pursue a known mix of strategies which could prevent the deaths of millions of women and children, invest in the health and education of the rising generation, and at the same time make a major contribution to the slowing-down of population growth. That mix of strategies is now within the capacity of any developing nation to implement and of any industrialized country to support.

On the Sunday before the Summit, over a million candles were lit for its success by ordinary people around the world. Each of those candles represented the inextinguishable hope in the hearts of people everywhere that, amid all the problems and the dangers of the years ahead, the world can still be made a better place. That hope has now taken on a definite form and a clear strategy. The challenge has been defined. Meeting that challenge will, as the Summit's Plan of Action says, "*demand* *consistent and extraordinary effort on the part of all concerned".*

On present trends, the number of children being born into the world each year is predicted to peak in about the year 2000 and begin to fall. The children of the 1990s will therefore be the largest generation ever to be entrusted to mankind. And the present generation will rightly be judged by how it meets the challenge of protecting their lives, their growth, their education, and their rights.

To guide that effort in the decade ahead, widespread acceptance must be won for a new ethic for children; an ethic which demands that children should be the first to benefit from mankind's successes and the last to suffer from its failures; an ethic which recognizes that it is on how society protects and cares for its children that its civilization is measured, its humanity is tested, and its future is shaped.

The full text of the 1991 State of the World's Children report is available from all UNICEF offices or by writing to the Division of Information, UNICEF House, 3 UN Plaza, New York, NY 10017, USA. The report is also published by Oxford University Press.

ADDRESS CORRECTION REQUESTED

The full text of the 1991 State of the World's Children report can be obtained from the Communications Department at the U.S. Comittee for UNICEF.

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